HEPATITIS C REFERRAL FORM

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis: ☐ B18.2 Hepatitis C Chronic **Genotype**: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **HIV Co-Infected:** ☐ Yes ☐ No

Compensated Cirrhosis? ☐ Yes ☐ No **Weight** _____ **Fibrosis Score**: _____ **Allergies:** _____

Previously Treated with Interferon? ☐ No, patient is Naïve ☐ Yes **If yes, patient is a:** ☐ Partial Responder ☐ Relapser ☐ Null Response

Labwork: **Baseline HCV-RNA:**_____ **Date:**_____ **Result:**_____ **IU/ml**

Harvoni & Sovaldi

Harvoni™ (ledipasvir and sofosbuvir)
☐ **Tablet** (90mg ledipasvir & 400mg sofosbuvir)
SIG: Take 1 pill once daily with or without food.
QTY: _____ Refill: _____

Sovaldi™ (sofosbuvir) ☐ **400 mg Tablet**
SIG: Take 1 pill once daily.
QTY: _____ Refill: _____

Daklinza

Daklinza™ (daclatasvir)
☐ **60mg tablet** ☐ **30mg tablet**
Take 1 tablet by mouth once daily with or without food in combination with Sovaldi.
QTY: 28 day supply Refill: _____
Recommended treatment duration: 12 weeks. Contraindicated if patient is on CYP3A Inducers, phenytoin, carbamazepine, rifampin, St. John's wort.

Epclusa

Epclusa™ (sofosbuvir and velpatasvir)
☐ **Tablet** (400mg sofosbuvir & 100mg velpatasvir)
SIG: Take 1 pill once daily with or without food.
QTY: _____ Refill: _____

Zepatier

Zepatier™ (elbasvir and grazoprevir)
☐ **One Monthly Carton**
SIG: Take 1 tablet once daily with or without food.
QTY: 28 day supply Refill:

Viekira

☐ **Viekira Pak™** ☐ **Viekira XR™**
SIG: Viekira Pak Take **2 ombitasvir / paritaprevir/ritonavir** tablets once daily (in the morning), and **1 dasabuvir** tablet twice daily (morning and evening).
Viekira XR ☐ Take **3 tablets once daily** with food.
QTY: 28 day supply (1 carton) Refill: _____

Technivie

Technivie™ ☐ **One Monthly Carton**
SIG: ☐ Take **2 ombitasvir/paritaprevir/ritonavir** tablets once daily in the morning with a meal
QTY: 28 day supply Refill:

Ribavirin

Ribavirin ☐ 200mg Caps ☐ 200 mg Tabs
SIG: ☐ **800mg/day:** 2 po AM & 2 po PM
☐ **1000mg/day:** 3 po AM & 2 po PM
☐ **1200mg/day:** 3 po AM & 3 po PM
☐ _____ QTY: _____ Refill: _____

Moderiba™ Dose Pack

☐ 600/600 ☐ 400/600 ☐ 400/400 ☐ 200/400
SIG: ☐ Take 1 tablet q AM and 1 tablet q PM
☐ _____ QTY: 56 tablets. Refill: ____

Hepatitis B: Vemlidy

Vemlidy™ ☐ 25 mg tablet
SIG: ☐ Take 1 tablet daily with food
☐ _____ QTY: 30 tablets. Refill: ____

Other/Notes:_____
_____
_____
_____
_____

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____

If Century Specialty Script is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353