DR. Rx. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

HEPATITIS C
REFERRAL FORM

Fax: **888.804.7717**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: ____________ **Rx**: ❑ New ❑ Refill ____________

PATIENT INFORMATION

Patient's Full Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________ Alt. Phone: ____________
Patient SS#: ____________ DOB: ____________
Allergies: ____________
Gender: ❑ Male ❑ Female ❑ See Attached Demographics

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Insurance: ____________
City: ____________ State: ____________
Plan No: ____________ Group No: ____________
Phone: ____________
Rx Card (PBM): ____________
PBM BIN: ____________
City: ____________ State: ____________
Group: ____________ Phone: ____________

DIAGNOSIS INFORMATION

Diagnosis:
❑ B18.2 Hepatitis C (Chronic)
❑ Other ICD 10 ____________
❑ Genotype: ____________
❑ Other ____________
Viral Load: ____________

Response Status:
❑ Naive
❑ Null
❑ Partial
❑ Relapse

Cirrhosis:
❑ Compensated
❑ De-compensated
❑ Hepatocellular Carcinoma
❑ HIV Status
❑ Post-Liver Transplant

Fibroscan: ❑ Yes ❑ No
Results: ____________
History of liver biopsy?: ❑ Yes ❑ No ❑ N/A
History of liver test?: ❑ Yes ❑ No ❑ N/A
Fibrosis present?: ❑ Yes ❑ No ❑ F3 ❑ F4
Fibro score: ____________ ❑ N/A IL28B genotype

Prior treatment:
Duration of prior treatment:
From ____________ To ____________
Total of ____________ Weeks
Co-infected with:
❑ HIV ❑ HBV ❑ N/A

- **Labs:** to be performed prior to therapy and monitored during treatment at appropriate intervals (particularly pregnancy test for woman of childbearing potential)
  ALT ________ AST ________ Hgb ________ Plt ________

- **Other medications** patient is currently taking (including OTC medications):
  ❑ See Med List ____________
- **Other disease states:** ❑ Depression ❑ Anxiety ❑ Diabetes ❑ Other____________

PRESCRIPTION INFORMATION

❑ **HARVONI® (Ledipasvir/Sofosbuvir)**
Take one tablet by mouth once daily, with or without food. 28 Day Supply Refills ________

DURATION OF THERAPY GUIDANCE FOR HCV GENOTYPE 1 PATIENTS

	Duration	Refills
Naive Non-Cirrhotic HCV RNA < 6 million IU *This can be considered by the medical provider.*	8 weeks	1
Naive Non-Cirrhotic HCV RNA > 6 million IU	12 weeks	2
Naive Non-Cirrhotic & Cirrhotic	12 weeks	2
Non-Responder Non-Cirrhotic	12 weeks	2
Non-Responder Cirrhotic	24 weeks	5

❑ **VIEKIRA PAK** (**Ombitasvir, paritaprevir**, and **ritonavir** tablets copackaged with **dasabuvir** tablets)
Refills ____________ Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (am & pm) with a meal.

❑ **RIBAPAK** ❑ **MODERIBA** ❑ **RIBAVIRIN** ❑ **OTHER**

ADULT DOSING:

Weight (lbs)	Weight (kgs)	Daily Dosage	Directions
		❑ 600 mg	Take 200mg po qAM and 400mg po qPM
		❑ 800 mg	Take 400mg po qAM and 400mg po qPM
❑ 165 & below	< 75	❑ 1000 mg	Take 600mg po qAM and 400mg po qPM
❑ 166 & above	> 75	❑ 1200 mg	Take 600mg po qAM and 600mg po qPM

Quantity: ____________ ❑ 28 day supply Refills: ________

NOTE: Ribavirin dosing is weight based (source: Schering) It is not based on individual Ribavirin package insert.

PROTEASE/POLYMERASE INHIBITOR

❑ **SOVALDI (sofosbuvir)** Dosage: 400mg (tab) QD; 28 Day Supply; Refills: ________

Dosing guidance for HCV Mono-Infected & HCV/HIV-1 Co-Infected Patients

HCV genotype	Regimen	Refills
1 or 4	Sovaldi + peg-interferon + ribavirin	x 2
2	Sovaldi + ribavirin	x 2
3 or IFN intolerant	Sovaldi + ribavirin	x 5

❑ **DAKLINZA (daclatasvir)** ❑ 60 mg ❑ 30 mg QD with Sovaldi Refills: ________

Patient Population	Treatment*	Duration
Genotype 3	Daklinza + Sovaldi	12 weeks

Dose Modification: Reduce dosage to 30 mg once daily with strong CYP3A inhibitors and increase dosage to 90 mg once daily with moderate CYP3A inducers.

❑ **TECHNIVIE (ombitasvir, paritaprevir, and ritonavir)**
Take 2 tablets by mouth once daily (in the morning) with a meal Refills: ________

Patient Population	Treatment*	Duration
Genotype 4 without cirrhosis	Technivie*	12 weeks

*Technivie administered without ribavirin for 12 weeks may be considered for treatment-naive patients who cannot take or tolerate ribavirin

❑ **OLYSIO (simeprevir) 150 mg**
Dosage: 150 mg (capsule) QD with food Qty: 28 Day Supply Refills: 2

❑ **OTHER** ____________
Dosage: ____________ Qty: ____________ Refills: ______

PRESCRIBER INFORMATION

Physician's Name (Please Print): ____________ NPI#: ____________
Address: ____________ License#: ____________
City, State, Zip: ____________ DEA#: ____________
Phone: ____________ Fax: ____________ Contact Name: ____________
Physician's Signature: ____________ Date: ____________

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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