HCV REFERRAL FORM

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex Male Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Diagnosis: B18.2 (Chronic HCV) Other:______________________________

Diagnosis Date: _______/_______/_________

Genotype: 1 1a* 1b 2 3 4 5

*NS5A polymorphism type: M28 Q30 L31 Y93 Other: ___________

Baseline viral load HCV RNA: ____IU

Date baseline viral load obtained: _______/_______/_________

Degree of Fibrosis: F1 F2 F3 F4 (Please indicate if cirrhotic.)

Cirrhosis: None Compensated Decompensated (CTP: B C)

Treatment Naive: Yes No (Response): Incomplete Treatement

Relapser Null Responder Partial Responder

Previous treatment regimen(s): ____

Co-infections: HIV HBV Post-Transplant Pre-Transplant

CKD Dialysis Other: ________________________________

PPI/H2 Antagonist During Treatment?: Yes No

If yes, was patient told to hold? Yes No

Additional Information

Today's Date	Delivery Date	Deliver to: Home Physician	Special Instructions

Existing treatment New Treatment Start **ANTICIPATED OR ACTUAL THERAPY START DATE: ______/______/________**

Prescription Information

MEDICATION	DOSE/STRENGTH/DIRECTIONS FOR USE	QTY	REFILLS
Epclusa® (velpatasvir 100mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
Harvoni® (ledipasvir 90mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
Mavyret® (glecaprevir 100mg/pibrentasvir 40mg)	Take three tablets by mouth once daily with food	84	
Vosevi® (sofosbuvir 400mg/velpatasvir 100mg/ voxilaprevir 100mg)	Take one tablet by mouth once daily with food	28	
Zepatier® (elbasvir 50mg/grazoprevir 100mg)	Take one tablet by mouth once daily (Please include results of NS5A resistance testing for GT 1a)	28	
Ribasphere® (ribavirin) 200mg Tablets/Capsules (unless otherwise specified, pharmacy prefer-ence/availability [or insurance preference] will be dispensed)	Take _______mg by mouth every morning and take ______mg by mouth every evening.	28-day	

Anticipated therapy duration: 8 weeks 12 weeks 16 weeks 24 weeks Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) DISPENSE AS WRITTEN/Do Not Substitute (date)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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