MEMORIAL HERMANN Specialty Pharmacy

HEPATITIS C REFERRAL FORM

Prescriber, please sign and fax completed form to 713.704.3841
For questions, please call 281.698.6100

SHIP TO: ☐ Patient ☐ Office (1st dose) ☐ Office (All doses)

Patient Information **Please include copy of prescription and medical card, front and back**

Patient Name: _____ Date of Birth: _____
Street Address: _____ Phone: _____
City, State, Zip: _____ Allergies: _____

Prescriber Information

Prescriber Name: _____ NPI: _____
Specialty: _____ Phone: _____
Office Street Address: _____ Fax: _____
City, State, Zip: _____ Office Contact: _____

Prescription Information		Quantity	Refills
☐ **Epclusa** (velpatasvir/sofosbuvir)	☐ Take 1 tablet by mouth once daily	☐ #28 (100 mg /400 mg tablets)	Refills:_____
☐ **Harvoni** (ledipasvir/sofosbuvir)	☐ Take 1 tablet by mouth once daily	☐ #28 (90 mg /400 mg tablets)	Refills:_____
☐ **Mavyret** (glecaprevir/pibrentasvir)	☐ Take 3 tablets by mouth once daily with food	☐ #84 (100 mg /40 mg tablets)	Refills:_____
☐ **Vosevi** (sofosbuvir/velpatasvir/ voxilaprevir)	☐ Take 1 tablet by mouth once daily with food	☐ #28 (400 mg/ 100 mg/ 100 mg tablets)	Refills:_____
☐ **Zepatier** (elbasvir/grazoprevir)	☐ Take 1 tablet by mouth once daily	☐ #28 (50 mg/100 mg tablets)	Refills:_____
☐ **ribavirin**	☐ Take ____mg in the AM and ____mg in the PM for a total of _____mg by mouth daily	☐ #____ (200 mg capsules or tablets)	Refills:_____
☐ **Other**_____	☐ Take _____ _____	☐ _____	Refills:_____

Expected Duration of Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Patient Medical Information **Please include copies of any pertinent clinical notes and lab work**

Required – complete this section for all patients	Required for clinically relevant patients only
Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) ☐ Other _____	Hemoglobin (if prescribed ribavirin): _____ Date: _____
Diagnosis date: _____	NS5A polymorphism (required for Zepatier in genotype 1a):
Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ N/A ☐ No ☐ Yes – Please fax results
Subtype: ☐ A ☐ B ☐ A/B ☐ N/A	Co-infection(s): ☐ N/A ☐ HIV ☐ HBV
Baseline viral load: _____IU/mL Date: _____	Hepatocellular carcinoma: ☐ No ☐ Yes
Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ _____	Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)	CKD stage: ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 – Dialysis: ☐ No ☐ Yes
Pregnant: ☐ N/A ☐ No ☐ Yes	SCr: _____ GFR: _____ Date: _____

Prior HCV Treatment History

☐ Treatment Naïve ☐ Treatment Experienced – List past medication regimen(s) below	Dates of Treatment	Duration
Medication(s): _____ ☐ Incomplete treatment ☐ Null Responder ☐ Partial Responder ☐ Relapser	_____ to _____	_____ Weeks
Medication(s): _____ ☐ Incomplete treatment ☐ Null Responder ☐ Partial Responder ☐ Relapser	_____ to _____	_____ Weeks

Prescriber Signature (no stamps permitted)

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.

Prescriber's Signature : _____ Date: _____

Print, sign, date, and fax to Memorial Hermann Specialty Pharmacy (713.704.3841)

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