**Hepatitis C**
**Prescription Referral Form**
**Bushnell: Phone: 1.352.793.8000**
**Fax: 1.352.793.8007**
**Wildwood: Phone: 1.352.748.9900**
**Fax: 1.352.748.9902**

SAFE SCRIPT PHARMACY
Bushnell | Wildwood
**www.safescriptpharmacy.com**

## 1. Patient Information

| | | | |
|---|---|---|---|
| Patient Name: | | SSN: | DOB: |
| Address: | City: | State: | Zip: |
| Home Phone: | Cell Phone: | Email Address: | |
| Sex: ☐Male ☐Female | Height: | Weight: ☐ lbs. ☐ kg. | Known Allergies: |

## 2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

## 3. Prescription Information: For IV medications attach a copy of your prescription

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign: _____

**Clinical information:**

**Responder status:**
❑ Treatment Naïve
❑ Treatment Experienced

**Prior Treatment:**
Type: _____

Did patient fail NS5A based treatment (Harvoni, Daklinza, Viekira, Zepatier)?
❑ No ❑ Yes (Please include RAV)

**Comorbidities:**
❑ ESRD
❑ HIV
❑ HBV
❑ Diabetes
❑ Other _____

**Fibrosis Stage:** _____

**Child-Pugh Score:** _____

**HCV genotype:**
❑ 1 ❑ 1a ❑ 1b
❑ 2 ❑ 2a ❑ 2b
❑ 3 ❑ 3a ❑ 3b
❑ 4 ❑ 4a ❑ 4b
❑ Other _____

**HCV RNA:** _____

**Cirrhosis:** ❑ Y ❑ N
**If YES:** ❑ Compensated
❑ Decompensated

☐ **EPCLUSA®** (Sofosbuvir 400mg/Velpatasvir 100mg)
Take 1 tablet by mouth daily, with or without food.
**Qty: 28 Day Supply** **Refills:**

☐ **Sofosbuvir 400mg/Velpatasvir 100mg**
Take 1 tablet by mouth daily, with or without food.
**Qty: 28 Day Supply** **Refills:**

☐ **HARVONI ®** (ledipasvir 90mg/sofosbuvir 400mg)
One tablet taken by mouth once daily.
**Qty: 28 Day Supply** **Refills:**

☐ **Ledipasvir 90mg/sofosbuvir 400mg**
One tablet taken by mouth once daily.
**Qty: 28 Day Supply** **Refills:**

☐ **SOVALDI™** (sofosbuvir)
Take 1 tablet by mouth daily, with or without food.
**Qty: 28 Day Supply** **Refills:**

☐ **Sofosbuvir**
Take 1 tablet by mouth daily, with or without food.
**Qty: 28 Day Supply** **Refills:**

☐ **DAKLINZA™** (daclatasvir) ☐ 60mg ☐ 30mg
Take 1 tablet by mouth daily, with or without food in combination with Sofosbuvir and ribavirin (600mg orally once daily).
**Qty: 28 Day Supply** **Refills:**

☐ **MAVYRET™** (glecaprevir/pibrentasvir)
Three tablets (total daily dose: glecaprevir 300mg and pibrentasvir 120mg) taken orally once daily with food.
**Qty: 28 Day Supply** **Refills:**

☐ **OLYSIO®** (Simeprevir)
Take 1 capsule by mouth daily with food (Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi).
**Qty: 28 Day Supply** **Refills:**

☐ **PEGASYS®** (Peginterferon alfa-2a) ☐ 90mcg ☐ 135mcg ☐ 180mcg
Inject ____ mcg under the skin once weekly
**Qty: 28 Day Supply** **Refills:**

☐ **RIBAVIRIN®** 200mg
_____ mg every morning _____ mg every evening
**Qty: 28 Day Supply** **Refills:**

☐ **TECHNIVIE™** (ombitasvir/paritaprevir/ritonavir tablets)
Take 2 ombitasivir/paritaprevir/ritonavir tablets by mouth once daily with a meal without regard to fat or calorie content (Technivie is FDA approved for use with ribavirin).
**Qty: 28 Day Supply** **Refills:**

☐ **VIEKIRA PAK™** (ombitasvir/paritaprevir/ritonavir tablets Co-packaged with dasabuvir tablets)
Take 2 ombitasvir/paritaprevir/ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (morning and evening) with a meal without regard to fat or calorie content.
**Qty: 28 Day Supply** **Refills:**

☐ **VIEKIRA XR™** (Coformulated: Dasabuvir/ombitasvir/paritaprevir/ritonavir)
Take 3 tablets daily with a meal without regard to fat or calorie Content
**Qty: 28 Day Supply** **Refills:**

☐ **VOSEVI™** (Sofosbuvir 400mg/Velpatasvir 100mg/Voxilaprevir 100mg)
Take 1 tablet by mouth daily with food
**Qty: 28 Day Supply** **Refills:**

☐ **OTHER**
**STREGNTH:**
**SIG/DIRECTIONS:**

☐ **ZEPATIER®** (elbasvir 50mg/grazoprevir 100mg)
Take 1 tablet by mouth daily, with or without food
**Qty: 28 Day Supply** **Refills:**

## 4. Physician Information:

| | | | |
|---|---|---|---|
| Prescriber Name: | Prescriber NPI: | DEA#: | |
| Address: | City: | State: | Zip: |
| Primary Office Contact: | Fax Number: | Phone Number: | |
| Office Contact Email: | | | |

**Prescriber Signature:** Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____



**This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.**