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





www.safescriptpharmacy.com

1. Patient Information									
Patie	ent Name:					SSN:		DOB:	
Address:					City:		State:	•	Zip:
Home Phone:			Cell Phone:			Email Add	dress:		
Sex: ☐ Male ☐ Female		Height:	١	Weight:	☐ lbs. ☐ kg	. Knowr	n Allergies:		
2. lr	surance 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									
Тор	revent generic substitution, Presc	riber to hand	write "Brand I	Medically N	Necessary" and	sign:			
	Responder status:	□ EPCLUSA®	(Sofosbuvir 400mg/Ve	elpatasvir 100mg)	·	□ Sofosbuvi	r 400mg/Velpat	asvir 100m	3
	☐ Treatment Naïve	Take 1 tablet by mouth daily, with or without food.				Take 1 tablet by mouth daily, with or without food.			
	☐ Treatment Experienced	Qty: 28 Day Supply Refills:			Qty: 28 Day Supply Refills:				
ion	Prior Treatment:	☐ HARVONI [®] (ledipasvir 90mg/sofosbuvir 400mg)			☐ Ledipasvir 90mg/sofosbuvir 400mg				
mat	Type:	One tablet taken by mouth once daily.				One tablet taken by mouth once daily.			
Clinical information:	Did patient fail NS5A based treatment	Qty: 28 Day Supply Refills:			Qty: 28 Day Supply Refills:				
al ir	(Harvoni, Daklinza, Viekira, Zepatier)?	□ SOVALDI™ (sofosbuvir)				□ Sofosbuvir			
inic	\square No \square Yes (Please include RAV)	Take 1 tablet by mouth daily, with or without food.				Take 1 tablet by mouth daily, with or without food.			
ט	Comorbidities:	Qty: 28 Day Supp	ly	Refills:		Qty: 28 Day Sup	pply	Refills:	
	□ ESRD	□ DAKLINZA"	(daclatasvir)	☐ 60mg ☐] 30mg	☐ MAVYRET	(glecaprevir/pibren	tasvir)	
	☐ HIV	,	mouth daily, with o				otal daily dose: gled		
	☐ HBV		nd ribavirin (600m	- '	aily).	pibrentasvir 120mg) taken orally once daily with food.			
	☐ Diabetes	Qty: 28 Day Supp OLYSIO® (Sin	•	Refills:		Qty: 28 Day Sup	oply Peginterferon alfa-2	Refills:	135mag 190mag
	☐ Other	,		f (Obi i	FDA - 1 - 1 - 1 - 1				1331110g 🗆 1801110g
	Fibrosis Stage:	Take 1 capsule by mouth daily with food (Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in				g under the skin ond			
	Child-Pugh Score:	combination with	Sovaldi).			Qty: 28 Day Sup	opiy	Refills:	
		Qty: 28 Day Supp	•	Refills:					
	HCV genotype:	☐ RIBAVIRIN®	200mg				E™ (ombitasvir/parita		,
	□ 1 □ 1a □ 1b	0 , 0			ng	Take 2 ombitasivir/paritaprevir/ritonavir tablets by mouth once daily with a meal without regard to fat or calorie content			
	□ 2 □ 2a □ 2b □ 3 □ 3a □ 3b	Qty: 28 Day Supply Refills:				•	A approved for use		
	□ 4 □ 4a □ 4b	☐ VIEKIRA PAK™ (ombitasvir/paritaprevir/ritonavir tablets Co-packaged with dasabuvir tablets)				Qty: 28 Day Supply Refills:			
	☐ Other	Take 2 ombitasvir/paritaprevir/ritonavir (pink tablets) once daily				☐ VIEKIRA X	(R™ (Coformulated: D	asabuvir/ombita:	svir/paritaprevir/ritonavir)
	HCV RNA:	(in the morning) and 1 dasabuvir (beige tablet) twice daily (morning			Take 3 tablets daily with a meal without regard to fat or calorie Content Oty: 28 Day Supply Refills:				
		and evening) with a meal without regard to fat or calorie content.							
		Qty: 28 Day Supply Refills: VOSEVITM (Sofosbuvir 400mg/Veloatasvir 100mg/Voxilaprevir 100mg)				□ OTHER			
	If YES: Compensated					STREGNTH:			
	☐ Decompensated	Take 1 tablet by mouth daily with food							
	·	Qty: 28 Day Supply Refills:			SIG/DIRECTI	ONS:			
		□ ZEPATIER® (elbasvir 50mg/grazoprevir 100mg)							
		Take 1 tablet by mouth daily, with or without food							
		Qty: 28 Day Supply Refills:							
4. P	hysician Information:	Qty. 20 Day Supp	ıy	iteliiis.					
Prescriber Name:			Prescribe	r NPI:		Г	EA#:		
Address:			City:			State:		Zip:	
Primary Office Contact:			Fax Number:			Phone Nu	mber:		
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 initiate 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								_	
	Confidentiality Statement: This message is inter information which is exempt from disclosure un	ded only for the individua der applicable laws, includ	I or entity to which it is ac ling the Health Insurance	ddressed. It may cont Portability and Accou	ain information which may b untability Act (HIPAA). If you a	e proprietary and confid are not the intended rec	dential. It may also contain cipient, please note that yo	privileged, confider ou are strictly prohib	ntial ited
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