HEPATITIS C REFERRAL FORM

Date: _____

Superior Pharmacy Solutions

Fax Referral To: 866-416-3656

Phone: 866-416-3655

SUPERIOR PHARMACY SOLUTIONS

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Physician 1st Order Only ☐ Physician All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN:_____ Group: _____

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis: ☐ 070.54 Hepatitis C Chronic **Genotype**: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 **HIV Co-Infected:** ☐ Yes ☐ No

Compensated Cirrhosis? ☐ Yes ☐ No **Weight** _____ **Patient Allergies:** ☐ NKDA ☐ Yes _____

Previously Treated with Interferon? ☐ No, patient is Naïve ☐ Yes **If yes, patient is a:** ☐ Partial Responder ☐ Relapser ☐ Null Response

Labwork: Baseline HCV-RNA:_____ **Date:**_____ **Result:**_____ **IU/ml**

Harvoni & Sovaldi

Harvoni™ (ledipasvir and sofosbuvir)

☐ **Tablet** (90mg ledipasvir & 400mg sofosbuvir)

SIG: Take 1 pill once daily with or without food.

QTY: _____ Refill: _____

Sovaldi™ (sofosbuvir) ☐ **400 mg Tablet**

SIG: Take 1 pill once daily.

QTY: _____ Refill: _____

Daklinza

Daklinza™ (daclatasvir)

☐ **60mg tablet** ☐ **30mg tablet**

Take **1 tablet** by mouth once daily with or without food in combination with Sovaldi.

QTY: 28 day supply Refill: _____

Recommended treatment duration: 12 weeks

Contraindicated if patient is on CYP3A Inducers, phenytoin, carbamazepine, rifampin, St. John's wort.

Olysio

Olysio™ (simeprevir)

☐ **150mg PO qDay** with food daily

QTY: _____ Refill:_____

Viekira

Viekira Pak™ ☐ **One Monthly Carton**

SIG: ☐ Take **2 ombitasvir/paritaprevir/ritonavir** tablets once daily (in the morning), and **1 dasabuvir** tablet twice daily (morning and evening)

QTY: 28 day supply Refill: _____

Technivie

Technivie™ ☐ **One Monthly Carton**

SIG: ☐ Take **2 ombitasvir/paritaprevir/ritonavir** tablets once daily in the morning with a meal

QTY: 28 day supply Refill: _____

Other/Notes:_____
_____
_____
_____
_____

Ribavirin

Ribavirin ☐ 200mg Caps ☐ 200 mg Tabs

SIG: ☐ **800mg/day:** 2 po AM & 2 po PM
☐ **1000mg/day:** 3 po AM & 2 po PM
☐ **1200mg/day:** 3 po AM & 3 po PM
☐ _____ QTY: _____ Refill: _____

Moderiba™ Dose Pack

☐ 600/600 ☐ 400/600 ☐ 400/400 ☐ 200/400

SIG: ☐ Take 1 tablet q AM and 1 tablet q PM
☐ _____

QTY: 56 tablets Refill:_____

Ribasphere RibaPak™

☐ 600/600 ☐ 400/600 ☐ 400/400 ☐ 200/400

SIG: ☐ Take 1 tablet q AM and 1 tablet q PM
☐ _____

QTY: 56 tablets Refill:_____

I authorize any division of Hometech Advanced Therapies to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to Superior Pharmacy Solutions, 2050 E. Algonquin Rd, Suite 606, Schaumburg, IL 60173. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original.

Patient Signature (required for participation) _____ **Date** _____

Prescriber Signature: _____ **DAW (Dispense as Written)** **Date:** _____