SpecialtyCareRx

□ **Orange,CA** P: (714) 941-6177 F: (714) 941-6178
□ **Las Vegas,NV** P: (702) 790-4404 F: (702) 790-4406
□ **Allen,TX** P: (469) 257-4200 F: (469) 795-9204
□ **Memphis,TN** P: (901) 560-3580 F: (901) 560-3581

QUALITY HOME INFUSION
PASSION FOR PUTTING PATIENTS FIRST

□ **Burbank,CA** P: (818) 848-8112 F: (818) 848-8142
□ **Las Vegas,NV** P: (702) 478-5133 F: (702) 478-5401

Hepatology/Gastroenterology Referral Form

Patient Information

Patient Name: _____ DOB: __/__/____
Sex: □ Femal □ Male SS#: ___-__-____ Language: _____
Allergies: _____ Wt: ____ □Kg □Lb Ht: ____ □Cm □In
Addess: _____ Apt/Suite: _____
City: _____ State: _____ Zip: _____
Phone: _____ Contact: _____ Relation: _____
Email Address: _____

Prescriber Information

Prescriber Name: _____ NPI: _____
If Shipping to prescriber: □ Initial Fill □ Always □ Never
Addess: _____ Apt/Suite: _____
City: _____ State: _____ Zip_____
Phone: _____ Contact: _____
Fax: _____ Alt. Fax: _____
Email Address: _____

INSURANCE INFORMATION (or attach copy of cards)

Medical Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____
Prescription Plan: _____ Policy #: _____ Policy Holder: _____ Relationship: _____

Clinical Information

Diagnosis (ICD-10): □ B17.10 □ B17.11 □ B18.1 □ B19.20 □ Other ICD: _____
HCV Genotype: □ 1a □ 1b □ 2 □ 3 □ 4 □ 5 □ 6
HCV RNA level (viral load) □ _____IU/mL □ Collection Date: _____
Cirrhosis: □ No □ Yes/ F-Score or Fibrosos Stage: _____
Treatment: □ Treatment naïve □ Treatment experienced/Brand Name & Stop Date: _____
Co-Infection: □ HIV/HCV □ HBV/HCV
Post-liver transplant □ No □ Yes/ Date of Transplant: _____

Required Chart Notes & Labs

□ Clinical Notes from most recent office visit.
□ Genotype – Copy of lab report.
□ CBC / including ALT, AST, SCr, etc. (Drawn in the past 90 days)
□ PT/NR – Prothrombin Time and International Normalize Ratio
□ Viral Load – HCV-RNA (Drawn in the past 90 days)
□ Fibrosis Score – Attach one of the following reports: Imaging/Fibrosure/Fibroscan/Fibrometer/Hepascore
□ Transplant status

Prescription Information

□ Epclusa+A33:K50 (sofosbuvir and velpatasvir)	400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	QTY: _____ Refills: _____
□ Harvoni (ledipasvir and sofosbuvir)	90 mg ledipasvir / 400 mg sofosbuvir	Take one tablet once daily with or without food. Do not take within 4 hours of antacids.	QTY: _____ Refills: _____
□ Mavyret (glecaprevir and pibrentasvir)	100 mg glecaprevir and 40 mg pibrentasvir	Take three tablets PO once a day with food.	QTY: _____ Refills: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Deliver to: □ Home □ Office □ Other: _____

If shipped to prescriber's office or infusion clinic, prescriber accepts on behalf of patient for administration in office or infusion clinic.
By signing this order, I, the prescriber, certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber's Signature _____ **Date: ___/___/_____**

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt 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 fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.