CALIFORNIA SPECIALTY PHARMACY

HEPATITIS C REFERRAL FORM

Physician must fax the completed referral form California Specialty Pharmacy at 866-853-6555

Your CSP Contact: _______________ and Tel: _______________

PATIENT INFORMATION:

Patient Name: ____________________
Address: ____________________
City: ____________________ State: _______ Zip: ___________
Home Phone: ____________________ Alternate Phone: ____________________
Email: ____________________
Soc. Sec#: _________________ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ ft ☐ cm
Date of Birth: ____________________ Sex: ☐ Male ☐ Female BSA: ____________

PHYSICIAN INFORMATION: Ship to: ☐ Physician's Office ☐ Patient's Home

Physician Name: ____________________
Address: ____________________
City: ____________________ State: _____ Zip: __________
Phone: ____________________ Fax: ____________________
Office Email: ____________________
Key Office Contact: ____________________
State LIC #: _______________ NPI# _________________ DEA# _________________

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

CLINICAL DIAGNOSIS: ***please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization***

Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) Diagnosis Date: _________________
Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Subtype: ☐ A ☐ B ☐ A/B ☐ N/A
Baseline Viral Load: ________________________ Date: ______________
Baseline of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ _______________
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)
Co-infection(s): ☐ None ☐ HIV ☐ HBV

Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant
sCr: ___________________ GFR: ___________________ Date: ______________
CKD stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ N/A Dialysis: ☐ Yes ☐ No
IL28B polymorphism: ☐ CC ☐ CT ☐ TT
Q80K polymorphism: ☐ Yes ☐ No NS5A polymorphism: ☐ Yes ☐ No
NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 ☐ _____________

Prior Regimen ☐ Naive ☐ Experienced(List below)	Start Date	End Date	Treatment Weeks	Response
				☐ IC ☐ NR ☐ PR ☐ RLP

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: ____________________________

MEDICATIONS & DIRECTIONS

Prescription	Directions	Quantity	Refill
☐ **Daklinza®** (daclatasvir)	☐ Take 30 mg by mouth once daily ☐ Take 60 mg by mouth once daily ☐ Take 90 mg by mouth once daily	☐ 28 x 30 mg tablets ☐ 28 x 60 mg tablets ☐ 28 x 90 mg tablets	_______
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐ Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	_______
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	_______
☐ **Mavyret™** (glecaprevir + pibrentasvir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 100 mg/40 mg tablets	_______
☐ **Olysio®** (simeprevir)	☐ Take 150 mg by mouth once daily	☐ 28 x 150 mg capsules	_______
☐ **Sovaldi®** (sofosbuvir)	☐ Take 400 mg by mouth once daily	☐ 28 x 400 mg tablets	_______
☐ **Technivie™** (ombitasvir/paritaprevir/ritonavir)	☐ Take 2 tablets by mouth in the morning with food	☐ 56 x 12.5 mg/75 mg/50 mg tablets	_______
☐ **Viekira Pak®** (dasabuvir/ ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	☐ 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	_______
☐ **Viekira XR™** (dasabuvir/ ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 200 mg/8.33 mg/50 mg/33.33 mg tablets	_______
☐ **Vosevi™** (sofosbuvir/velpatasvir/voxilaprevir)	☐ Take 1 tablet by mouth once daily with food	☐ 28 x 400 mg/100 mg/100 mg tablets	_______
☐ **Zepatier™** (elbasvir/grazoprevir)	☐ Take 50 mg/100 mg by mouth once daily	☐ 28 x 50/100 mg tablets	_______
☐ **Ribasphere® Ribapak®** Dose Pak (ribavirin) ☐ **Moderiba™** Dose Pack® (ribavirin)	☐ Take _________ mg tablet by mouth every morning, _________ mg tablet by mouth every evening (_________ mg/day)	☐ 28 x 200 mg; 28 x 400 mg tablets ☐ 28 x 400 mg; 28 x 400 mg tablets ☐ 28 x 400 mg; 28 x 600 mg tablets ☐ 28 x 600 mg: 28 x 600 mg tablets	_______
☐ **Ribasphere®**** (ribavirin)	☐ Take _________ mg tablet by mouth every morning, _________ mg tablet by mouth every evening (_________ mg/day)	☐ _____ x 200 mg tablets ☐ _____ x 200 mg capsules	_______

**For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (or insurance preference) will be dispensed.*

Per state-specific laws, prescriptions will be dispensed as generic, If applicable, unless notated otherwise: ____

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED ______ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		

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