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MedRX Infusion
www.medrxinfusion.com

Hepatitis C Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____

Diagnosis:_____ Viral Load/Date:_____ / _____ HIV status: ☐ + ☐ -

Genotype:_____ Fibrosis score:_____(kPa) Child-Pugh Class:_____ Cirrhosis: ☐ compensated ☐ decompensated

Prior Therapies: _____ Patient treated on therapy: ☐ Y ☐ N

4. Prescription Information ☐ DAW1- Dispense as written. Do not substitute for generic

Medication	Dose	Directions	Dispense	Refill
☐ **Epclusa** (Sofosbuvir and Velpatasvir)	☐ 200mg/50mg Tablets ☐ 400mg/100mg Tablets	Take 1 tablet PO daily for total 12 weeks Other: _____	28 tabs	
☐ **Harvoni** (Ledipasvir and Sofosbuvir)	☐ 45mg/200mg Tablets ☐ 90mg/400mg Tablets	Take 1 tablet PO daily for total 12 weeks Other: _____	28 tabs	
☐ **Mavyret** (Glecaprevir and Pibrentasvir)	100mg/40mg Tablets	Take 3 tablets PO daily for total 12 weeks Other: _____	84 tabs	
☐ **Ribavirin**	200mg capsules or tablets	_____	_____	
☐ **Sovaldi** (Sofosbuvir)	400mg Tablets	Take 1 tablet PO daily for total 12 weeks Other: _____	28 tabs	
☐ **Vosevi** (Sofosbuvir/ Velpatasvir/ Voxilaprevir)	400mg/ 100mg/ 100mg Tablets	Take 1 tablet PO daily for total 12 weeks Other: _____	28 tabs	
☐ **Zepatier** (Elbasvir and Grazoprevir)	50mg/100mg Tablets	Take 1 tablet PO daily for total 12 weeks Other: _____	28 tabs	
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____