SpecialtyCareRx

□ **Las Vegas,NV**	P: (702) 790-4404	F: (702) 790-4406	□ **Orange,CA**	P: (714) 941-6177	F: (714) 941-6178
□ **Allen,TX**	P: (469) 257-4200	F: (469) 795-9204	□ **Burbank,CA**	P: (818) 848-8112	F: (818) 848-8142
□ **Memphis,TN**	P: (901) 560-3580	F: (901) 560-3581	□ **Marrero, LA**	P: (504) 340-5221	F: (504) 340-5228

Hepatology/Gastroenterology Referral Form

Patient Information	Prescriber Information
Patient Name: ___________________________ DOB: __/__/____	Prescriber Name: ___________________ NPI: ___________
Sex: □ Femal □ Male SS#: ___-__-____ Language: ______	If Shipping to prescriber: □ Initial Fill □ Always □ Never
Allergies: _____________ Wt: ____ □Kg □Lb Ht: ____ □Cm □In	Address: ___________________________ Apt/Suite: ______
Addess: ________________________________ Apt/Suite: ________	City: __________________ State: ________ Zip________
City: _________________ State: ___________ Zip: ____________	Phone: ________________ Contact: ____________________
Phone: _______________ Contact: _________ Relation: ________	Fax: ______________ Alt. Fax: ____________________
Email Address: ____	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.
“ Referral forms are not valid in Arizona, providers can phone or electronically send in orders.”