

# HEPATITIS B & C REFERRAL FORM

(Specialty Pharmacy)



## PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

## REQUIRED DOCUMENTATION

- Insurance Card      • Recent Clinicals & Labs      • Patient Demographics      • Tried/Failed Therapies      • Med List
- Genotype:  1  2  3  4  5  6    Subtype:  A  B  A/B  N/A    • Baseline viral load: \_\_\_\_\_ IU/mL
- Cirrhosis:  Y  N (if yes, is it:  compensated  decompensated)    • Co-infection status:  HIV  HBV  N/A
- Degree of liver fibrosis:  F0  F1  F2  F3  F4    • Polymorphism(s):  NS5A  IL28B  Q80K  N/A
- Is patient:  Naïve  Partial Responder  Non-Responder  Relapser; Prior Treatment: \_\_\_\_\_

## PRIMARY DIAGNOSIS

- B18.1 Chronic Hepatitis B Virus (HBV)       B18.2 Chronic Hepatitis C Virus (HCV)
- Other: \_\_\_\_\_

## PRIMARY MEDICATION ORDER

New  Refill    Ship by: \_\_\_\_/\_\_\_\_/\_\_\_\_    Ship to:  Patient's Home  Doctor's Office  Other: \_\_\_\_\_

DRUG	STRENGTH	DIRECTIONS & QUANTITY	REFILLS
Vemlidy	<input type="checkbox"/> 25mg tablet	<input type="checkbox"/> Take 1 tablet PO daily with food (Qty: 28)	
Viread	<input type="checkbox"/> 300mg tablet	<input type="checkbox"/> Take 1 tablet PO daily with or without food (Qty: 28)	
Eplclusa	<input type="checkbox"/> 400/100mg tablet	<input type="checkbox"/> Take 1 tablet PO daily with or without food (Qty: 28)	
Harvoni	<input type="checkbox"/> 90/400mg tablet	<input type="checkbox"/> Take 1 tablet PO daily with or without food (Qty: 28)	
Mavyret	<input type="checkbox"/> 100/40mg tablet	<input type="checkbox"/> Take 3 tablets PO daily with food (Qty: 84)	
Vosevi	<input type="checkbox"/> 400/100/100mg tab	<input type="checkbox"/> Take 1 tablet PO daily with food (Qty: 28)	
Zepatier	<input type="checkbox"/> 50/100mg tablet	<input type="checkbox"/> Take 1 tablet PO daily with or without food (Qty: 28)	

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Practice Name:	Phone:
Address:	<input type="checkbox"/> Email:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI:	License:
	Tax ID:

Provider Signature (no stamps)

Date

To Prescriber: By signing this form and utilizing our services, you are also authorizing FlexCare to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and copay assistance foundations.

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