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Hepatitis C Virus Referral Form

Publix Specialty Pharmacy (#3212)

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Orlando, FL 32809

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Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/___ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs/tests and office notes] Previously denied by insurance: No Yes, include copy of denial letter

Diagnosis code: B18.2 Other: _____ Genotype and subtype: _____ Baseline viral load (VL): _____ Date of VL: ___/___/___

NS5A polymorphism present: Yes No N/A; Q80K polymorphism present: Yes No N/A; Co-infections: None HIV Hep B Other: _____

Fibrosis score: 0 1 2 3 4; Cirrhosis: No Compensated Decompensated; SrCr: _____ mg/dL, CrCl _____ mL/min, Date of SrCr: ___/___/___

Treatment status: Naïve Experienced, prior therapy: _____; Treatment duration (weeks): 8 12 16 24 Other: _____

Other pertinent past medical history and/or drug therapy: _____

Weight: _____ kg lb Height: _____ cm in Allergies: NKDA Other _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY (28 day supply)	REFILLS
<input type="checkbox"/> Epclusa (velpatasvir/ sofosbuvir)	100/400 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Vosevi (velpatasvir/ sofosbuvir/ voxilaprevir)	100/400/100 mg tablet	Take 1 tab PO once daily with food	28	_____
<input type="checkbox"/> Harvoni (ledipasvir/ sofosbuvir)	90/400 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Zepatier (elbasvir/ grazoprevir)	50/100 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir)	100/40 mg tablet	Take 3 tabs PO once daily with food	84	_____
<input type="checkbox"/> Technivie (ombitasvir/ paritaprevir/ ritonavir)	12.5/75/50 mg tablet	Take 2 tabs PO once daily in AM with food	56	_____
<input type="checkbox"/> Viekira XR (ombitasvir/ paritaprevir/ ritonavir/ dasabuvir)	8.33/50/33.33/200 mg tablet	Take 3 tabs PO once daily with food	84	_____
<input type="checkbox"/> Viekira Pak (ombitasvir/ paritaprevir/ ritonavir and dasabuvir)	12.5/75/50 mg tablet and 250 mg tablet	Take 3 tabs PO in AM and 1 tab PO in PM with food as directed	112	_____
<input type="checkbox"/> Daklinza (daclatasvir)	<input type="checkbox"/> 60 mg tablet <input type="checkbox"/> 30 mg tablet	<input type="checkbox"/> Take 1 tab PO once daily with or without food	28	_____
		<input type="checkbox"/> Take 3 tabs (90 mg) PO once daily with or without food (if on strong CYP3A4 inducer)	84	_____
<input type="checkbox"/> Sovaldi (sofosbuvir)	400 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Olysio (simeprevir)	150 mg capsule	Take 1 cap PO once daily with food	28	_____
<input type="checkbox"/> Ribasphere (ribavirin) <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <i>If dosage form not specified, availability or insurance preference will be used</i>	Patient weight: _____ <input type="checkbox"/> 200 mg (generic available) <input type="checkbox"/> 400 mg <input type="checkbox"/> 600 mg	<input type="checkbox"/> >75 kg: Take 600 mg PO BID with food	<input type="checkbox"/> 168 for 200mg <input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> ≤ 75 kg: Take 600 mg PO in AM and 400mg PO in PM with food	<input type="checkbox"/> 140 for 200mg <input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> Other: _____	_____	_____

Prescriber Information [Ship to prescriber: Never Always First fill only, appointment date: ___/___/___] Use Cover My Meds: Yes No

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ Date _____
(stamps not accepted) Substitution allowed Dispense as written/ Do not substitute

For states requiring hand written expressions to prevent substitution, write here:

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