Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Hepatitis C Prescription Referral Form

Send your RX to: | Access Specialty Pharmacy
Fax: 661-489-3553 | If you have any questions or concerns, Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ Deliver to: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up Injection training by pharmacy? _____

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. Kg.
Soc. Sec #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please Fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Provider Name: _____ DEA #: _____ NPI#: _____
Address: _____ Phone: _____ Fax: _____
City, State, ZIP: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

Diagnosis/ICD-10: _____ **Genotype: 1a 1b 2 3 4 5 6** **Viral Load:** _____
Date: _____
Fibrosis Score: F0 F1 F2 F3 F4 **Cirrhosis: ☐None ☐Compensated ☐Decompensated** **Child-Pugh: ☐A ☐B ☐C**
IL-28B: ☐CC ☐CT ☐TT **NS5A Polymorphism: ☐Y ☐N** **NS5A Polymorphism type: ☐28 ☐30 ☐31 ☐93**
Other _____ **☐ HIV Co-infection ☐ HBV Co-infection**

Prior Therapy	End Date	Treatment Weeks	Response Status to Previous Treatment
_____	_____	_____	○ Naïve ○ non-responder/ Null ○ Partial responder ○ Re-lapser
_____	_____	_____	○ Naive ○ non-responder/Null ○ Partial responder ○ Re-lapser

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Epcluza** (Sofosbuvir, Velpatasvir)	☐ 400mg/100mg	☐ Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Harvoni** (Ledipasvir, Sofosbuvir)	☐ 90mg/400mg	☐ Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Mavyret** (Glecaprevir, Pibrentasvir)	☐ 100mg/40mg	☐ Take 3 tablets once daily with food	28 day supply	
☐ **Pegasys** • Prefilled syringe • Vial • ProClick	☐ 180mcg ☐ 135mcg	☐ 180mcg SQ once weekly ☐ 90mcg SQ once weekly ☐ 135mcg SQ once weekly	28 day supply	
☐ **Solvadi**	☐ 400mg	☐ Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Technivie** (Ombitasvir, Paritaprevir, Ritonavir)	☐ 12.5mg/75mg/50mg	☐ Take 2 tablets by mouth once daily in the morning with a meal without regard to fat or calorie content *(Technivie is FDA approved for use with Ribavirin)*	28 day supply	
☐ **Viekira Pak** (Ombitasvir, Paritaprevir and Ritonavir tablets copackaged with Dasabuvir tablets) ☐ **Viekira XR**	☐ 12.5mg/75mg/50mg/ 250mg ☐ 8.33mg/50mg/33.33mg/ 200mg	☐ Take 2 pink tablets (Ombitasvir, Paritaprevir and Ritonavir) once daily in the morning and 1 beige tablet (Dasabuvir) twice daily (morning and evening) with a meal without regard to fat or calorie content ☐ Take 3 tablets once daily	28 day supply	
☐ **Vosevi** (Sofosbuvir, Velpatasvir, Voxilaprevir)	☐ 400mg/100mg/100mg	☐ Take 1 tablet by mouth daily with food	28 day supply	
☐ **Zepatier** (Elbasvir, Grazoprevir)	☐ 50mg/100mg	☐ Take 1 tablet by mouth daily, with or without food	28 day supply	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ **Date:** _____

Prescriber Signature: Prescriber, please sign and date below

_____ _____ _____ _____
Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions:

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