Sterling SPECIALTY PHARMACY

Hepatitis C
Prescription Referral Form

NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: ❑ Male ❑ Female Height: _____ Weight: _____ ❑ lbs. ❑ kg.

Allergies: _____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other: _____ ❑ Hearing Impaired

Patient Phone: _____ Patient Email: _____ Caregiver Name: _____

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

2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10: _____ **Diagnosis Date:** _____ **Other:** _____

Genotype: ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 **Fibrosis Score:** ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4

Cirrhosis: ❑ None ❑ Compensated ❑ Decompensated **Child-Pugh:** ❑ A ❑ B ❑ C

Liver Biopsy: ❑ Yes ❑ No **HIV Co-Infection:** ❑ Yes **HBV Co-Infection:** ❑ Yes

Does the patient need a liver transplant? ❑ Yes

Prior Therapy: _____ **End Date:** _____

Treatment Weeks: _____ **Response:** ❑ None ❑ Partial ❑ Relapse

LABS: ALT: _____ AST: _____ PLT: _____ HGB: _____ HCV RNA: _____

SrCr: _____ NS5A Resistance Assay: _____ Date: _____

Duration of Therapy: ❑ 8 Weeks ❑ 12 Weeks ❑ 24 Weeks ❑ Other: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Naïve:

❑ Yes ❑ No **If no, list prior failed treatments below.**

Treatment Type:	Drug Name:	Dates of Use:
❑ _____	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
❑ DAKLINZA™	❑ 30mg Tablets ❑ 60mg Tablets ❑ 90mg Tablets	❑ Take one tablet by mouth daily (with or without food) in combination with Sovaldi (with or without Ribavirin). ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ EPCLUSA®	❑ 400mg/100mg Tablets	❑ Take one tablet by mouth daily with or without food. ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ HARVONI®	❑ 400mg/90mg Tablets	❑ Take one tablet by mouth daily with or without food. ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ MAVYRET™	❑ 100mg/40mg Tablets	❑ Take three tablets by mouth daily with food. ❑ Other: _____	❑ 84 ❑ ____	❑ ____
❑ OLYSIO®	❑ 150mg Capsules	❑ Take one capsule by mouth daily with food. ❑ Other: _____ *(Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi)*	❑ 28 ❑ ____	❑ ____
❑ RibaSphere® RibaPak® ❑ MODERIBA™ Dose Pack	❑ 600mg *(total dose per day)* ❑ 800mg *(total dose per day)* ❑ 1000mg *(total dose per day)* ❑ 1200mg *(total dose per day)*	❑ 200mg every morning and 400mg every evening. ❑ 400mg every morning and 400mg every evening. ❑ 600mg every morning and 400mg every evening. ❑ 600mg every morning and 600mg every evening. ❑ Other: _____	❑ ____	❑ ____
❑ RibaSphere® ❑ MODERIBA™ ❑ RIBAVIRIN®	❑ 200mg Capsules ❑ 200mg Tablets	❑ Take _____ ❑ capsules ❑ tablets every morning. ❑ Take _____ ❑ capsules ❑ tablets every morning. ❑ Other: _____	❑ ____	❑ ____
❑ SOVALDI®	❑ 400mg Tablets	❑ Take one tablet by mouth daily with or without food. ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ VOSEVI™	❑ 400mg/100mg/100mg Tablets	❑ Take one tablet by mouth daily with food. ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ XIFAXAN®	❑ 550mg Tablets	❑ Take two tablets by mouth daily with or without food. ❑ Other: _____	❑ 60 ❑ ____	❑ ____
❑ ZEPATIER®	❑ 50mg/100mg Tablets	❑ Take one tablet by mouth daily with or without food. ❑ Other: _____	❑ 28 ❑ ____	❑ ____
❑ _____	❑ _____	❑ _____	❑ ____	❑ ____

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

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

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.