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.

Date Medication Needed:____________ **Ship to:** ☐ Patient's Home ☐ Prescriber's Office ☐ Pharmacy to Coordinate

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: ________ Secondary Phone:________ Patient Email:____________ Caregiver Name:____________

Patient Address:____________ City:____________ State:____ Zip:______

2 Provider/Prescriber Information

Clinic Name:____________ Provider Name:____________ DEA#:________ NPI#:________

Provider Address:____________ City:____________ State:____ Zip:______

Key Contact:____________ Phone:________ Fax:________ Email:____________

3 Diagnosis/Clinical Information

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

Diagnosis/ICD-10:________ Diagnosis Date:________ **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:________

Medication List and Contraindications: ☐ Attach Medication List **Is the patient interferon ineligible?** ☐ Yes ☐ No
☐ Anxiety ☐ Depression ☐ Pulmonary Abnormalities ☐ Renal Insufficiency ☐ Other:____________

If Prior Authorization is Denied: Sterling will inform provider of preferred formulary alternatives and/or draft an appeal letter as advisable.

4 Prescription Information

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

Patient Name:____________ Patient Birthdate:____________

Duration of Therapy: ☐ 8 Weeks ☐ 12 Weeks ☐ 24 Weeks ☐ Other: ____________

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

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

Dispense as written:____________ Date:________ Substitution Permissable:____________ Date:________

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.

# of Prescriptions:________

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

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