COOKEVILLE REGIONAL MEDICAL CENTER
It's the Way WeCARE

Hepatitis C Referral Form

FOR INFORMATION
Specialty Services: (931) 783-5551
Fax referral #: (931) 783-5533
Outpatient Pharmacy
931-783-2552 phone
931-783-2553 fax

Referral Info

PATIENT INFORMATION

Patients Name:	SSN#:		DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:	Diagnosis Code:		

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

MAVYRET™ (glecaprevir/pibrentasvir)
❑ Three tablets (total daily dose: glecaprevir 300mg and pibrentasvir 120mg) taken orally once daily with food
Qty: 28 Day Supply Refills:

HARVONI® (ledipasvir 90mg/sofosbuvir 400mg)
❑ One tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

DAKLINZA™ (daclatasvir)
❑ 30mg ❑ 60mg
_____ mg taken once daily with or without food.
*Combination with sofosbuvir
Qty: 28 Day Supply Refills:

EPCLUSA® (Sofosbuvir 400mg/Velpatasvir 100mg)
❑ One tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

VOSEVI™
(Sofosbuvir 400mg/Velpatasvir 100mg/Voxilaprevir 100mg)
❑ One tablet taken by mouth once daily with food.
Qty: 28 Day Supply Refills:

ZEPATIER® (elbasvir 50mg/grazoprevir 100mg)
❑ One tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

SOVALDI™ (sofosbuvir)
❑ One 400mg tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

❑ **RIBAVIRIN®** 200mg **Qty:**
_____ mg AM _____ mg PM Refills:

Please use this section for additional directions or other medications not listed.

❑OTHER

STRENGTH:

SIG/DIRECTIONS

QUANTITY: **REFILLS:**

Clinical Info

Responder status:
❑ Treatment Naïve ❑ Treatment Experienced
Prior Treatment:
Type:_____

Did patient fail NS5A based treatment (Harvoni, Daklinza,Viekira,Zepatier)?

❑ No ❑ Yes (Please include RAV)

Comorbidities:
❑ ESRD
❑ HIV
❑ HBV
❑ Diabetes
❑ Other _____

Fibrosis Stage: _____
Child-Pugh Score:_____

HCV genotype:
❑ 1 ❑ 2 ❑ 3 ❑ 4
❑ 1a ❑ 2a ❑ 3a ❑ 4a
❑ 1b ❑ 2b ❑ 3b ❑ 4b
❑ Other _____

HCV RNA: _____

Cirrhosis: ❑ Y ❑ N
If YES: ❑ Compensated ❑ Decompensated

Test Type	Quest Lab	LabCorp
GT1 NS5A RAV Test	92447(X)	550325
Genotype + GT1a RAV (reflex) panel	93871(X)	550615
Viral Load + GT1a RAV (reflex) panel	N/A	550333 (graphical) 550349 (non-graphical)
Viral Load + Genotype (reflex) + GT1a RAV (reflex) panel	93873(X)	550705

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact/Faxed by:	Email:	
NPI#:	TAX ID#:	Deliver To: ❑Patient ❑MD 1st Fill Only ❑MD All Orders
Prescriber Signature		
❑ Dispense as written	Date	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.