EL NORTE
Retail & Specialty Pharmacy

HEPATITIS C REFERRAL FORM

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed: _________ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION				PRESCRIBER INFORMATION	
Patient Name				**Prescriber Name**	
Address				**NPI**	
City, State, Zip				**Address**	
Primary Phone		**Alt. Phone**		**City, State, Zip**	
Date of Birth		**Allergies**		**Office Phone:**	
Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
Insurance	PLEASE FAX A COPY OF INSURANCE CARD(S)			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ Chronic Hepatitis C ❑ Hepatic Failure without coma ❑ Liver Cell Carcinoma ICD10 Code: _________ ❑ Other: _______________

Genotype: ________ **Viral Load**: _____________ IU/mL **Date of Viral Load:** __________ **Cirrhosis**: ❑ Yes ❑ No ❑ Compensated ❑ Decompensated

Hepatitis B Test: ❑ Positive ❑ Negative **Date of Test**: ___________ **HIV Test:** ❑ Positive ❑ Negative **Fibrosis Score:** _________________

Tried/Failed Previous Therapies: ❑ Naive ❑ Relapsed ❑ Partial Responder ❑ Non-responder

Please List Previous Therapies: ____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **DAKLINZA**	❑ 30mg ❑ 6mg	❑ Take 1 tablet once daily with or without food	❑ 28 days	
❑ **EPCLUSA**	❑ 400mg/ 100mg	❑ Take 1 tablet once daily	❑ 28 days	
❑ **HARVONI**	❑ 90mg/ 400mg	❑ Take 1 tablet once daily	❑ 28 days	
❑ **MAVYRET**	❑ 100mg/ 40mg	❑ Take 3 tablets (contents of one daily dose card) by mouth once daily with food	❑ 28 days	
❑ **SOVALDI**	❑ 400mg	❑ Take 1 tablet once daily with or without food	❑ 28 days	
❑ **TECHNIVIE**	❑	❑ Take 2 tablets once daily in the morning with food	❑ 28 days	
❑ **VIEKIRA**	❑ Viekira XR	❑ Take 3 tablets once daily	❑ 28 days	
	❑ Viekira Pak	❑ Take 2 tablets of ombitasvir, paritaprevir, ritonavir once daily in the morning and 1 dasabuvir 250mg tablet twice daily with a meal		
❑ **VOSEVI**	❑ 100 mg	❑ Take 1 tablet once daily with food	❑ 28 days	
❑ **ZEPATIER**	❑ 50mg/ 100mg	❑ Take 1 tablet once daily with or without food (Please include NS5A resistance testing)	❑ 28 days	
❑ **RIBAVIRIN**	❑ 200mg	❑ < 75kg – 1000mg/ day – Take 3 tablets daily in the morning and 2 tablets in the evening ❑ > 75kg – 1200mg/day – Take 3 tablets twice daily ❑ Other: ___________________________________	❑ 28 days	
❑ **RIBAPAK**	❑ 600mg/ 600mg ❑ 600mg/ 400mg ❑ 400mg/ 400mg ❑ 200mg/ 400mg	❑ Take 1 tablet twice daily (morning and evening)	❑ 28 days	
❑ **MODERIBA**	❑ 200 mg ❑ 600mg/ 600mg ❑ 600mg/ 400mg ❑ 400mg/400mg ❑ 200mg/400mg	❑ Take 1 tablet twice daily (morning and evening) ❑ Other: ________________________________	❑ 28 days	
❑ **OTHER**	❑	❑	❑ 28 days	

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: ____ Date: _______________________________________

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