AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

HEPATITIS C REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ B18.2 ☐ B18.1 ☐ Other ICD 10: _____

☐ Treatment naïve ☐ Treatment experienced ☐ Decompensated Cirrhosis ☐ Compensated Cirrhosis

- If applicable: ☐ Co-infected HIV / HCV ☐ HBV / HCV
- Prior therapies and reasons for stopping (if applicable): _____
- Other medications patient is currently taking (including OTC medications): _____

CLINICAL INFORMATION REQUIRED

- **Please attach the following Clinical Information:**

☐ Clinical Notes from most recent office visit
☐ Genotype – Copy of lab report
☐ CBC / *including ALT, AST, SCr, etc.* *(Drawn in the past 90 days)*
☐ Urine drug screen *(If applicable)*
☐ NS5A resistance-associated polymorphisms lab *(If applicable)*
☐ PT/NR – Prothrombin Time & International Normalize Ratio
☐ Viral Load – HCV-RNA *(Drawn in the past 90 days)*
☐ Treatment readiness assessment *(If applicable)*
☐ Fibrosis Score – Attach one of the following reports: Imaging / Fibrosure / Fibroscan / Fibrometer / Hepascore
☐ Transplant status
☐ Other: _____

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **Epclusa®** [sofosbuvir / velpatasvir] **400 mg / 100 mg tablet** 1 tablet PO once daily	QTY: 28 | Refills:
☐ **Epclusa®** [sofosbuvir / velpatasvir] **200 mg / 50 mg tablet** 1 tablet PO once daily (**Pediatric:** +3 y/o, 17-30 kg)	QTY: 28 | Refills:
☐ **Epclusa®** [sofosbuvir / velpatasvir] **150 mg / 37.5 mg pellets** 1 packet PO once daily (**Pediatric:** +3 y/o, < 17 kg)	QTY: 28 | Refills:
☐ **Harvoni®** [ledipasvir / sofosbuvir] **90 mg / 400 mg tablet** 1 tablet PO once daily	QTY: 28 | Refills:
☐ **Harvoni®** [ledipasvir / sofosbuvir] **45 mg / 200 mg tablet** 1 tablet PO once daily (**Pediatric:** +3 y/o, 17-35 kg)	QTY: 28 | Refills:
☐ **Harvoni®** [ledipasvir / sofosbuvir] **33.75 mg / 150 mg pellets** 1 packet PO once daily (**Pediatric:** +3 y/o, < 17 kg)	QTY: 28 | Refills:
☐ **Sovaldi®** [sofosbuvir] **400 mg tablet** 1 tablet PO once daily	QTY: 1 Month | Refills:
☐ **Mavyret®** [glecaprevir and pibrentasvir] **100 mg / 40 mg tablet** 3 tablets PO once daily with food	QTY: 1 Month | Refills:
☐ **Ribavirin®** ☐ **200 mg tablet** ☐ **200 mg capsule** Directions: _____	QTY: 1 Month | Refills:
☐ **Vosevi®** [sofosbuvir / velpatasvir / voxilaprevir] **400 mg / 100 mg / 100 mg tablet** 1 tablet PO once daily with food	QTY: 1 Month | Refills:
☐ **Zepatier®** [elbasvir / grazoprevir] **50 mg / 100 mg tablet** 1 tablet PO once daily NS5A resistance-associated polymorphisms: ☐ None ☐ M28 ☐ Q30 ☐ L31 ☐ Y93	QTY: 1 Month | Refills:
☐ **Other:** _____	QTY: | Refills:

Intended combination therapy duration: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other: _____

I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to: AcariaHealth 6923 Lee Vista Blvd, Suite 300 Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original. **Patient Signature:** _____ **Date:** _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.