HEPATITIS C REFERRAL FORM A - M

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Epclusa (sofosbuvir/velpatasvir)	400/100mg Tablet	Take 1 tablet by mouth once daily.	28 tablets	
☐ Harvoni (ledipasvir/sofosbuvir)	90/400mg Tablet	Take 1 tablet by mouth once daily.	28 tablets	
☐ Mavyret (glecaprevir/pibrentasvir)	100/40mg Tablet	Take 3 tablets by mouth once daily with food.	84 tablets (28-day supply)	

Treatment History: ☐ **Treatment Naive** ☐ **Non-Response** ☐ **Null-Response** ☐ **Partial-Response** ☐ **Relapsed**
(list below): _____

Co-infection(s)
☐ HIV
☐ Other _____

Hepatitis B Screening Results:
☐ HBsAg: ☐ Anti-HBc:
☐ Anti-HBs:

Fibrosis Score
☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Cirrhosis Status
☐ None ☐ Compensated ☐ Decompensated - CTP Class

HCV RNA Level _____ IU/ml Date Drawn _____ Polymorphisms (if applicable) _____

Duration of Current Treatment
☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other: _____ weeks

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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HEPATITIS C REFERRAL FORM N - V

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco. | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Ribavirin Patient weight: _____kg	☐ 200mg Tablet	☐ <75kg: Take 600mg by mouth in the morning and 400mg by mouth in the evening.	140 tablets (28-day supply)	
	☐ 200mg Capsule	☐ ≥75kg: Take 600mg by mouth in the morning and 600mg by mouth in the evening.	168 tablets (28-day supply)	
		Other:		
☐ Sovaldi (sofosbuvir)	400mg Tablet	Take 1 tablet by mouth once daily.	28 tablets	
☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	400/100/100mg Tablet	Take 1 tablet by mouth once daily with food.	28 tablets	

Treatment History: ☐ **Treatment Naive** ☐ **Non-Response** ☐ **Null-Response** ☐ **Partial-Response** ☐ **Relapsed**
(list below): _____

Co-infection(s)
☐ HIV
☐ Other _____

Hepatitis B Screening Results:
☐ HBsAg: ☐ Anti-HBc:
☐ Anti-HBs:

Fibrosis Score
☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Cirrhosis Status
☐ None ☐ Compensated ☐ Decompensated - CTP Class

HCV RNA Level_____Iu/ml Date Drawn_____ Polymorphisms (if applicable)_____

Duration of Current Treatment
☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other:_____weeks

Prescriber Information

Prescriber Name: _____
State License #:_____ DEA #: _____ NPI:_____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone:_____
Fax:_____ Email Address: _____
Address: _____ City: _____ State:_____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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HEPATITIS C REFERRAL FORM W – Z

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel-Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Phone: _____ Cell Phone: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
ICD-10 Diagnosis Code: _____ Diagnosis: _____
Allergies (please note reaction): _____ ☐ Latex
Current Medications: (list here or attach a medication list): _____
_____
Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Zepatier (elbasvir/grazoprevir)	50/100mg Tablet	Take 1 tablet by mouth once daily.	28 tablets	
Other Medication Name:				

Treatment History: ☐ **Treatment Naive** ☐ **Non-Response** ☐ **Null-Response** ☐ **Partial-Response** ☐ **Relapsed**
(list below): _____

Co-infection(s)
☐ HIV
☐ Other _____

Hepatitis B Screening Results:
☐ HBsAg: ☐ Anti-HBc:
☐ Anti-HBs:

Fibrosis Score
☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Cirrhosis Status
☐ None ☐ Compensated ☐ Decompensated - CTP Class

HCV RNA Level _____ IU/ml Date Drawn _____ Polymorphisms (if applicable) _____

Duration of Current Treatment
☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other: _____ weeks

Prescriber Information

Prescriber Name: _____
State License #: _____ DEA #: _____ NPI: _____
Additional Contact Person Name: _____
Group or Hospital: _____ Phone: _____
Fax: _____ Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____

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