

HEPATITIS C REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040



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): _____

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

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Daklinza (daclatasvir)	<input type="checkbox"/> 30mg Tablet	Take 1 tablet by mouth once daily.	28	
	<input type="checkbox"/> 60mg Tablet			
	<input type="checkbox"/> 90mg Tablet			
<input type="checkbox"/> Epclusa (sofosbuvir/velpatasvir)	400/100mg Tablet	Take 1 tablet by mouth once daily.	28	
<input type="checkbox"/> Harvoni (ledipasvir/sofosbuvir)	90/400mg Tablet	Take 1 tablet by mouth once daily.	28	
<input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir)	100/40mg Tablet	Take 3 tablets by mouth once daily with food.	84 (28-day supply)	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg Tablet	<input type="checkbox"/> <75kg: Take 600mg by mouth in the morning and 400mg by mouth in the evening.	140 (28-day supply)	
	<input type="checkbox"/> 200mg Capsule	<input type="checkbox"/> ≥75kg: Take 600mg by mouth in the morning and 600mg by mouth in the evening.	168 (28-day supply)	
		Other:		
<input type="checkbox"/> Sovaldi (sofosbuvir)	400mg Tablet	Take 1 tablet by mouth once daily.	28	
<input type="checkbox"/> Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	400/100/100mg Tablet	Take 1 tablet by mouth once daily with food.	28	
<input type="checkbox"/> Zepatier (elbasvir/grazoprevir)	50/100mg Tablet	Take 1 tablet by mouth once daily.	28	
Other Medication Name:				

Prescription information continued on next page

Treatment History: **Treatment Naive** **Non-Response** **Null-Response**
 Partial-Response **Relapsed**

Co-infection(s)

HIV
 Other _____

Hepatitis B Screening Results:

HBsAg:
 Anti-HBs:
 Anti-HBc:

Fibrosis Score

F0 F1 F2 F3 F4

Cirrhosis Status

None Compensated Decompensated - CTP Class

HCV RNA Level _____ 1u/ml Date Drawn _____

Polymorphisms (if applicable) _____

Duration of Current Treatment

8 weeks 12 weeks 24 weeks Other: _____ weeks

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

Date

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.

Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____

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Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
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Prescription
Information - Continued

Prescriber
Information

Delivery
Information