CureStat Rx
Home Infusion and Specialty Pharmacy

HEPATITIS C REFERRAL FORM

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____
Please fax a copy of front and back of the insurance card(s).

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Clinical Information (Please fax pertinent lab information)

Diagnosis: ☐ B17.10 Acute Hepatitis C without hepatic coma ☐B17.11 Acute Hepatitis C with hepatic coma ☐B18.2 Chronic Hepatitis C
☐B19.20 Unspecified Viral Hepatitis C without hepatic coma ☐ Other (ICD-10 code with description): _____
Wt: _____ ☐ Kg ☐ lbs Ht: _____ ☐ cm ☐ in Genotype ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Subtype ☐ A ☐ B ☐ A/B ☐ N/A
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated Child-Pugh ☐A ☐ B ☐ C Co-infection: ☐ None ☐ HIV ☐ HBV
Baseline viral load: _____ Date: _____ NS5A polymorphism: ☐ Yes ☐ No NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 _____

Prior Therapy ☐ Naive ☐ Experienced	Start date	End Date	Treatment Weeks	Response Status
				☐ Incomplete treatment ☐ Null ☐ Partial ☐ Relapse
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Allergies: ☐ NKDA ☐ Other: _____
Comorbidities: _____

Drug	Dose/Strength	Directions	Qty	Refills
☐ **DAKLINZA** (daclatasvir)	☐ 30mg Tablet ☐ 60mg Tablet ☐ 90mg Tablet	☐ Take 30 mg by mouth once daily ☐ Take 60 mg by mouth once daily ☐ Take 90 mg by mouth once daily		
☐ **EPCLUSA** (velpatasvir/sofosbuvir)	☐ 100/40mg tablet	☐ Take 100 mg/400 mg by mouth once daily		
☐ **HARVONI** (ledipasvir/sofosbuvir)	☐ 90/400mg tablet	☐ Take 90 mg/400 mg by mouth once daily		
☐ **MAVYRET** (glecaprevir + pibrentasvir)	☐ 100/40mg tablet	☐ Take 3 tablets by mouth once daily with food		
☐ **OLYSIO** (simeprevir)	☐ 150mg capsule	☐ Take 150 mg by mouth once daily		
☐ **PEGASYS** (peginterferon alfa-2a)	☐ 180 mcg/mL vial ☐ 180 mcg/0.5 mL Prefilled syringe ☐ 180 mcg/0.5 mL autoinjector	☐ Inject 180mcg SC once a week ☐ Other: _____		
☐ **RIBASPHERE** ☐ **RIBAPAK DOSE PAK** ☐ **MODERIBA DOSE PACK** (ribavirin)	☐ 200mg/400mg tablets ☐ 400mg/400mg tablets ☐ 400mg/600mg tablets ☐ 600mg/600mg tablets	☐ Take _____mg by mouth every morning and _____mg by Mouth every evening		
☐ **SOVALDI** (sofosbuvir)	☐ 400mg tablet	☐ Take 400 mg by mouth once daily		
☐ **VIEKIRA PAK** (dasabuvir/ombitasvir/ paritaprevir/ritonavir)	☐ 12.5/75/50 mg tablet & 250 mg tablet	☐ Take two ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg tablets in the morning and one dasabuvir 250 mg tablet twice daily with a meal		
☐ **VOSEVI** (sofosbuvir/velpatasvir/ voxilaprevir)	☐ 400/100/100mg tablet	☐ Take 1 tablet by mouth once daily with food		
☐ **ZEPATIER** (elbasvir/grazoprevir)	☐ 50/100mg tablet	☐ Take 1 tablet by mouth once daily		

☐ Product Substitution permitted ☐ Dispense as written
Prescriber's Signature: _____ Date: _____