MEDQUICK PHARMACY

Hepatitis C Virus (HCV) Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information

Name (last, first)	Phone ❑ Home ❑ Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP
Social Security Number	❑ Male ❑ Female	Allergies

Healthcare Provider Information

Prescriber's First and Last Name	Phone	Fax
Address, City, State		ZIP

Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No

Clinical Information *(Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization process)*

Genotype:
❑ 1 ❑ 3
❑ 1a ❑ 4
❑ 1b ❑ 5
❑ 2 ❑ 6

Date of Diagnosis: _____
❑ Treatment Naïve ❑ Non-Responder
❑ Retreatment / Relapser
❑ Previous Treatment (if any) and date: _____
_____
Treatment Failure due to: _____

❑ Patient is pregnant/planning pregnancy
ICD-9 Code: ❑ 070.54
❑ Other: _____
❑ Previous Transplant:_____
Height: _____ Weight: _____

Liver Biopsy: ❑ YES ❑ NO If YES: ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑F4
HCV RNA: _____ Date: _____ (must be drawn within last 6 months)
❑ HIV Co-infect ❑ Cirrhosis If YES: ❑ Compensated ❑ Decompensated
Other Health Conditions: _____
Allergies: _____Concomitant Meds: _____

Medication

Please Arrange Labs

- ❑ Hepatic Function Panel
- ❑ CBC (Includes Differential and Platelets)
- ❑ BUN, Creatinine
- ❑ Hepatitis B Surface Antibody, Qualitative
- ❑ Hepatitis A Antibody, Total
- ❑ Hepatitis B Surface Antigen with Reflex Confirmation
- ❑ Hepatitis B Core Antibody, Total
- ❑ HIV Antibody, HIV-1/2, EIA, with Reflexes
- ❑ Hepatitis C Viral RNA, Viral Load, Genotype, LIPA
- ❑ Alpha Feto Protein
- ❑ Complete Metabolic Panel
- ❑ PT, PTT, INR
- ❑ Liver Fibrosis, Fibrotest Actitest Panel
- ❑ Alcohol and Drug Screen Comprehensive, with Confirmation, Urine

❑ **Sovaldi®** 400mg tablets
1 PO once daily
Quantity: 28 Refills: _____

❑ **Daklinza™ Tablets** ❑30 mg ❑60 mg
1 PO once daily
Quantity: 28 Refills: _____

❑ **Ribasphere® (Ribavirin 200mg) TableTs**
❑ 600mg: 200mg QAM/400mg QPM
❑ 800mg: 400mg QAM/400mg QPM
❑ 1000mg: 600mg QAM/400mg QPM
❑ 1200mg: 600mg QAM/600mg QPM
❑ Other: _____
Quantity: _____ Refills: _____

❑ **Viekira pak®**
Use 1 pak PO (am and pm dose) daily
Quantity: 112 Refills: _____

❑ **Harvoni® Tablets** 90mg/400mg
1 Tab PO once daily
Quantity: 28 Refills: _____

❑ **Technivie Tablets** 12.5 - 75 mg
1 Tab PO once daily
Quantity: 28 Refills: _____

❑ **Olysio™ Capsule** 150mg
1 PO once daily with food
Quantity: 28 Refills: _____

FAX results to MedQuick Pharmacy 626-281-2055, MD: _____

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature:_____ Date ____/____/____

I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

The PRINT CENTER

FAX APPROVAL SHEET

Date 10/05/2015

1 Total of pages this one included (If more than 1, sign each page)

To:
Company:
F/E:

From: Taylor
Tel: 310-247-0234
print@gotoprintcenter.com

☐ Another proof is required

☐ O.K. to print (Approved)

Signature

Date

Please PROOF-READ and FAX or EMAIL with either your CHANGES or APPROVAL.

FAX: 310-247-0545 or print@gotoprintcenter.com

AFTER YOUR APPROVAL ALL CUSTOM ORDERS ARE FINAL

PLEASE TAKE A MOMENT AND CAREFULLY PROOFREAD FOR:

• Typographical Errors • Typestyles • Position • Proportions • Color • Layout

Clearly mark all changes, check appropriate box above, sign and return to us. If proof is emailed, send an email approval "OK to print".We regret any errors that may go undetected but it is your responsibility to verify that this is correct before going to production. **WE ARE NOT RESPONSIBLE** for the remake of your die(s) or foil stamped materials and, or printed materials once your proof has been approved. Thank you for your prompt and careful attention.