MED CENTER SPECIALTY PHARMACY

Dedicated to Improving Our Patients' Health

Part of The Elwyn Pharmacy Group

August 2017

HEPATITIS C FOR MEDICAID PATIENTS REFERRAL FORM

3100 MacCorkle Avenue S.E. | Suite 100
Charleston, WV 25304
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Previously treated ☐ No ☐ Yes, what drugs _____ Interferon ☐ Yes ☐ No # of Weeks _____
ICD-10 Code ☐ B18.2 HCV (Chronic) ☐ B19.2 F Score_____ ☐ relapsed ☐ partial response ☐ null response
Cirrhosis ☐ Yes ☐ No ☐ Compensated ☐ Decompensated
HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **MAVYRET** 100 mg glecaprevir / 40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets by mouth daily with food Qty: 84 Refills: _____
☐ Other:_____ Qty:_____ Refills: _____

☐ **VOSEVI** 400 mg sofosbuvir / 100 mg velpatasvir / 100 mg voxilaprevir tablet
SIG: ☐ Take 1 tablet by mouth daily for 12 weeks Qty:_____ Refills: _____
☐ Other:_____ Qty:_____ Refills: _____

☐ **EPCLUSA** Sofosbuvir 400 mg / Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tablet by mouth daily for 12 weeks
☐ Take 1 tablet by mouth daily for 12 weeks WITH Ribavirin
QTY: 28 Refills: _____

☐ **HARVONI** Ledipasvir 90mg / Sofosbuvir 400mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____

DAKLINZA ☐ 30 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: _____
☐ 60 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: _____
☐ 90 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: _____
SIG: take 1 tablet each dailly Total daily dose:_____ GT3 ONLY

☐ **RIBAVIRIN** ☐ **MODERIBA** ☐ **RIBAPAK**
☐ 600mg PO Daily; 200mg QAM, 400mg QPM
☐ 800mg PO Daily; 400mg QAM, 400mg QPM
☐ 1000mg PO Daily; 600mg QAM, 400mg QPM
☐ 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ Other 200mg Sig _____
Qty: 28 Day Supply Refills: _____

☐ **TECHNIVIE** paritaprevir / ritonavir (75/50 mg) and ombitasvir (12.5 mg)
SIG: two tablets QAM with meal and with ☐ RIBAVIRIN
Qty: 28 Day Supply Refills: _____ GT4 ONLY

☐ **OLYSIO** 150mg capsule Qty: 28 Refills: _____
SIG: Take 1 capsule by mouth daily for 12 wks w/ peginterferon and ribavirin

☐ **SOVALDI** (Sofosbuvir) 400mg tablet
SIG: Take 1 tablet by mouth daily Qty: 28 Refills: _____

☐ **ZEPATIER** Grazoprevir 100mg/ Elbasvir 50mg tablet
SIG: Take one tablet by mouth daily Qty: 28 Refills: _____

PEG INTRON ☐ REDIPEN ☐ VIAL
Strength (Dose) ☐ 50mcg/0.5ml ☐ 120mcg/0.5ml
☐ 80mcg/0.5ml ☐ 150mcg/0.5ml
Directions _____
Quantity: ☐ 1 month ☐ 3 months Refills: _____

PEGASYS
☐ **ProClick** 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ **Pre-Filled Syringe** 180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly
☐ Other _____
Quantity: ☐ 1 month ☐ 3 months Refills: _____

☐ **VIEKIRA XR** Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO QAM with meal for:
☐ 12 weeks w/ Ribavirin (GT 1a, w/o cirrhosis)
☐ 24 weeks w/ Ribavirin (GT 1a, w/ compensated cirrhosis)
☐ 12 weeks (GT 1b, w/ or w/o compensated cirrhosis)
Qty: 84 Refills: _____

☐ **VIEKIRA PAK** QTY: 112 Refills: _____
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige)
Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food

NEUPOGEN ☐ 300 mcg ☐ 480mcg
Sig _____ Qty:_____ Refills: _____
PROCRIT
Sig _____ Qty:_____ Refills: _____

OTHER _____
Sig _____ Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.com** for online fillable forms.

NEW REFERRAL CHECKLIST
FOR HEPATITIS C MEDICAID PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. Most Medicaid plans require the following lab values obtained within the last 3 months.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Albumin
- ☐ ANA
- ☐ Bilirubin (direct and total)
- ☐ Blood alcohol level
- ☐ CBC with diff
- ☐ Child- Pugh score if available
- ☐ Cirrhosis (decompensated or compensated)
- ☐ ECG (if heart disease present)
- ☐ Genotype
- ☐ GFR
- ☐ Glucose
- ☐ HCV RNA (viral load)
- ☐ HIV serology (CD4 + T-cell count and HIV RNA)
- ☐ Iron study
- ☐ LFTs
- ☐ Liver biopsy/Fibroscan (preferred)/ARFI
- ☐ NS5A Lab (required for Zepatier 1a patients)
- ☐ Pregnancy test (for women of child bearing age)
- ☐ PT/INR
- ☐ Serum HBsAg, anti-HBc, anti-HBs, anti-HAV
- ☐ Serum creatinine
- ☐ Stage of fibrosis ____
- ☐ TSH
- ☐ Uric acid
- ☐ Urine drug screen

THE FOLLOWING CLINICAL INFORMATION IS REQUIRED IN ADDITION TO THE ABOVE LAB WORK

- ☐ Patient should be enrolled in the Health Plan's Hepatitis C Adherence program if applicable
- ☐ Psychiatric history and clearance to start therapy
- ☐ Clinical finding of extrahepatic manifestations or cirrhosis
- ☐ If patient has a drug/alcohol history, clinical notes are needed documenting abstinence from illicit drugs and alcohol for at least 6 months
- ☐ Previous treatment regimen:_____
- ☐ Dates of previous treatment:_____
- ☐ Previous treatment outcome: Non-responder, partial responder, relapse, discontinued
- ☐ Reason for discontinuation: _____
- ☐ Documentation that patient agrees to use 2 or more forms of contraception and will have monthly pregnancy test
- ☐ Documentation of liver transplant or hepatocellular carcinoma if applicable
- ☐ Complete medical history and medication list

Fax the requested documentation to (304) 344-0655

Toll Free: 1-855-633-5633 Direct Phone: (304) 344-8021

MedCenterSpecialtyPharmacy.com

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