US Bioservices
AmerisourceBergen

Hepatitis C Referral Form

Phone: (866) 223-7914
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Last Name: _____ Home Phone:_____ Work/Mobile Phone:_____

First Name: _____ Home Address:_____

S.S. #:_____ Date of Birth:_____ City:_____ State:_____ Zip:_____

Guardian/Caregiver:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____ Secondary ICD-10:_____ Degree of Fibrosis:_____ Fibroscan (0-75):_____ Fibrotest (0.00-1.00):_____

Concurrent Medications:_____ Genotype:_____ Viral Load:_____ Viral Load Date:_____

Allergies:_____ **Duration of Treatment:** From _____ to _____. Total of _____ wks

Meds Tried & Failed:_____ ☐ Treatment Naive ☐ Partial Responder ☐ Previous Treatment:_____

History of Liver Biopsy? ☐ Yes ☐ No ☐ N/A ☐ Responder/Relapser ☐ Non-responder ☐ Other:_____

Cirrhosis: ☐ None ☐ Compensated ☐ De-compensated **ALT:**_____ **AST:**_____ **Hgb:**_____ **Plt:**_____

Transplant status: ☐ Pre-transplant ☐ Post-transplant ☐ N/A Serum Creatine (SCr):_____ Date of last lab draw:_____

HIV co-infection: ☐ Yes ☐ No **HBV co-infection/history:** ☐ Yes ☐ No Other Disease States:_____

5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
MAVYRET™	☐ *Glecaprevir, pibrentasvir:* 100/40 mg tab	• Take three tabs PO once daily with food	**28 Days**	
VOSEVI™	☐ Sofosbuvir,velpatasvir, voxilaprevir: 400/100/100 mg tab	• Take one tab PO daily with food	**28 Days**	
ZEPATIER®	☐ Elbasvir, grazoprevir: 50/100 mg tab	• Take one tab PO daily with/without food	**28 Days**	
EPCLUSA®	☐ Sofosbuvir,velpatasvir: 400/100 mg tab	• Take one tab PO daily with/without food	**28 Days**	
HARVONI®	☐ Ledipasvir, sofosbuvir: 90/400 mg tab	• Take one tab PO daily with/without food	**28 Days**	
SOVALDI®	☐ Sofosbuvir: 400 mg tab	• Take one 400mg tab PO daily with/without food	**28 Days**	
RIBASPHERE®	☐ 200 mg tab ☐ 200 mg capsule	• Take_____mg PO AM and _____mg PO PM	**28 Days**	
Other:			**Days**	
Other:			**Days**	

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date _____ / _____ / _____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices to act on behalf of myself and my patient to initiate any de minimis authorization process from health plans including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____