



Hepatitis C Virus (HCV) Referral Form

Dedicated HCV Enrollment Phone: (855) 896.9255 Fax: (402) 896.4862



Patient Information					
IMPORTANT: Please Fax a Copy of Patient's Insurance Card (Front and Back)					
Last Name	First Name	Home Phone	Work/Mobile Phone	Date of Birth	
Home Address			City	State ZIP	
Shipping Address (if different from above)			City	State ZIP	
Social Security Number	Gender (M/F)	Primary Caregiver Name and Phone	Emergency Contact Name and Phone		
Clinical Assessment					
Please FAX recent clinical notes, labs, tests, with the prescription to expedite the Prior Authorization process					
Genotype: ☐ 1 ☐ 1a* ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 *For Genotype 1a, is the Q80K polymorphism present? ☐ Yes ☐ No Date of Diagnosis: _____					
ICD-9 Code: ☐ 070.54 ☐ Other: _____ Patient Height: _____ Patient Weight: _____ ☐ Patient is pregnant/planning pregnancy					
Allergies: _____ Concomitant Meds: _____ ☐ Previous transplant: _____					
☐ Awaiting Transplant ☐ Treatment Naïve ☐ Non-Responder ☐ Retreatment/Relapser ☐ HIV Co-infect ☐ Cirrhosis If YES: ☐ Compensated ☐ Decompensated					
☐ Other Health Conditions: _____ ☐ Previous Treatment (if any) and date: _____ Treatment Failure due to: _____					
Does patient have any unique circumstances that would interfere with adherence to prescribed medication regimen? (If yes, please explain): _____					
Liver Biopsy: ☐ Yes ☐ No If YES: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 HCV RNA: _____ Date: _____ (must be drawn within last 6 months)					
Healthcare Provider Information					
*Indicates Required Field					
Practice/Facility Name		Physician First and Last Name*	Phone*	Fax	
Address*		City*	State*	ZIP*	
Physician NPI#*	Nurse/Key Contact	Phone or Pager #	Email		
Additional Information					
Today's Date	Delivery Date	Deliver to: ☐ Home ☐ Physician	Nurse Training Needed? ☐ Yes ☐ No	Special Instructions	
Medication					
Medication		Dose/Strength/Directions for Use		Quantity	Refills
☐ Daklinza™ The recommended starting dose of Daklinza is 60mg once daily; decrease to 30mg when given with strong CYP3A inhibitors; increase to 90mg when given with moderate CYP3A inducers.		☐ Take one 60mg tablet by mouth once daily with or without food		28 day supply	
		☐ Take one 30mg tablet by mouth once daily with or without food		28 day supply	
☐ Harvoni® (ledipasvir/sofosbuvir)		90mg/400mg tablet once daily		28 day supply	
☐ Olysio™ *Document Q80K Result Above		150mg once daily with food		28 day supply	
☐ Sovaldi®		400mg once daily		28 day supply	
☐ Technivie™ (ombitasvir/paritaprevir/ritonavir)		Take two 12.5mg/75mg/50mg tablets by mouth once daily (in the morning) with a meal		28 day supply	
☐ Ribapak® DAW		☐ 600mg: 200mg QAM/400mg QPM ☐ 1000mg: 600mg QAM/400mg QPM		28 day supply	
☐ Moderiba™ DAW		☐ 800mg: 400mg QAM/400mg QPM ☐ 1200mg: 600mg QAM/600mg QPM			
☐ Ribasphere® (Ribavirin 200mg)		☐ Other: _____			
☐ Peg-Intron® ☐ Redipen ☐ Vials		☐ 50mcg SQ q week ☐ 80mcg SQ q week ☐ 120mcg SQ q week ☐ 64mcg SQ q week ☐ 96mcg SQ q week ☐ 150mcg SQ q week		28 day supply	
☐ Pegasys® ☐ ProClick ☐ PFS ☐ Vial		☐ Inject 180mcg SQ q week as directed ☐ Inject 90mcg SQ q week as directed ☐ Inject 135mcg SQ q week as directed		28 day supply	
☐ Promacta® ☐ 12.5mg tablet Qty: _____ ☐ 25mg tablet Qty: _____ ☐ 50mg tablet Qty: _____ ☐ 75mg tablet Qty: _____		Directions for Use: _____			
☐ Other: _____					
Intended combination therapy duration: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other:					

Physician Signature: _____ Date ____/____/____

I authorize Amber 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.