Hepatitis C Referral Form
Please fax to:
866.279.3315

Patient Name:		Primary Ins:		
DOB:		BinRx/PCN#:		
SSN:		ID#:		
Address:		Group#:		
City/ST/Zip:		Phone#:		
Phone#:		Secondary Ins:		
Emergency contact#		Sex: M F		
Diagnosis:		Height: Weight: Allergies:		
ICD-10:		List Previous Treatment:		
Liver Biopsy:		Genotype:		Viral Load:
HIV: Y N		Naive: Y N Relapser: Non Responder:		
___Vosevi (400mg sofosbuvir/100mg velpatasvir/voxilaprevir 100mg) Directions: Take 1 tablet daily with food QTY: 28 REFILLS ____	____Mavyret (100 mg glecaprevir/40mg pibrentasvir) Directions: Take 3 tablets daily with food QTY: 84 REFILLS _____	___ Zepatier (50mg elbasvir/100mg grazoprevir) Directions: Take 1 tablet daily with or without food QTY: 28 REFILLS ____	___ Harvoni (90 mg ledipasvir/400 mg sofosbuvir) Directions: Take 1 tablet daily with or without food QTY: 28 REFILLS ____	___ Daklinza (daclatasvir) ___ 60 mg one daily ___ 30 mg once daily QTY: 28 REFILLS ____
____ Epclusa (400 mg sofosbuvir/100mg velpatasvir) Directions: Take 1 tablet daily with or without food QTY: 28 REFILLS ____	___Sovaldi (400 mg sofobuvir) Directions: Take 1 tablet daily QTY: 28 REFILLS ____	___ Viekira Pak (12.5mg ombitasvir/75mg paritaprevir/50mg ritonavir) (dasabuvir 250mg) Directions: Take 2 pink tablets and 1 biege tablet in the morning with food. Take 1 biege tablet in the evening with food QTY: 4 boxes for 28 days REFILLS ____	___Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir extended-release) Directions: Take 3 tablets once daily with a meal QTY: 84 REFILLS ____	___Technivie (12.5 mg ombitasvir/75 mg paritaprevir/50mg ritonavir) Directions: Take 2 tablets once daily QTY: 56 REFILLS ____
Ribapak ____ Moderiba _____ Weight: _____ kg/lbs ____ 600mg PO Daily: 200mg QAM, 400mg QPM ____800mg PO Daily: 400mg QAM. 400mgQPM 103-131 ____1000mg PO Daily: 600mg QAM. 400mg QPM 132-162 ____1200mg PO Daily: 600mg QAM. 600mg QPM >162 QTY____ REFILLS____		Ribasphere 200mg_____ Moderiba 200mg____ Dose: (If insurance does not cover Ribapak, we will automatically switch to the equivalent dose of Ribasphere 200mg tabs) QTY____ REFILLS____		
_____ Xifaxan __200mg tablet __550mg tablet Dose: __ one tablet twice daily __one tablet three times daily __ _____ QTY:_____ REFILLS_____		___ other QTY: ____ REFILLS ____	**Supportive Therapy** __Procrit __Neupogen __Epogen Dosing: _____ QTY: ____ REFILLS ____	**Deliver to:** Patient's home ____ MD's Office ____ First dose to MD ____ Physician Training in office __

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

Physician Signature DAW Substitution Allowed: Date:

Physician Name:	Office Contact:	
Address:	Phone:	Fax:
City/St/Zip:	NPI:	DEA: