Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Hepatitis C Virus

Referral for Medication and Patient Management Program

OptiMed

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name _____ Sex ☐M ☐F
DOB _____ SSN _____
Phone _____ 2nd Phone _____
Address _____ Apt/Suite _____
City, State, ZIP _____
Primary language, if other than English _____

Provider Information

Prescriber _____
NPI _____ DEA _____
Practice Name _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____ Key contact _____

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other _____

Clinical Information

Diagnosis ☐ B18.2 Chronic HCV ☐ Other (include ICD-10) _____
Diagnosis Date _____ **Genotype** ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
HCV-RNA Viral Load _____ **VL Date** _____
Metavir Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Cirrhosis ☐ None ☐ Compensated ☐ Decompensated **Child-Pugh** ☐ A ☐ B ☐ C
Other marker(s) of liver fibrosis _____
Previous treatment ☐ No, naïve Yes, ☐ Null ☐ Partial ☐ Relapsed
If yes, list **medications, dates, and duration of previous therapy** _____
_____
_____

Weight _____ ☐ lb ☐ kg **Height** _____ ☐ in
Allergies _____
HBV negative or treated ☐ Yes ☐ No
Medical history (please check all that apply)
☐ HIV co-infection ☐ HBV co-infection ☐ History of renal failure
Liver transplant status: ☐ N/A ☐ Post-transplant ☐ Waiting for transplant
Resistance testing performed ☐ Yes ☐ No
NS5A polymorphism at position ☐ 28 ☐ 30 ☐ 31 ☐ 93 ☐ Other ____ ☐ None
Other notable polymorphism ☐ No ☐ Yes _____
_____

Please submit hard copies of latest H&P, CBC, CMP, genotype, viral load, and liver biopsy/fibrosis assessment.

Medication	Directions	Quantity	Refills	Treatment Duration
☐ **Epclusa®** 100mg/400mg (velpatasvir/sofosbuvir)	Take one tablet PO once daily.	4-week supply	_____	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks
☐ **Harvoni®** 90mg/400mg (ledipasvir/sofosbuvir)	Take one tablet PO once daily.	4-week supply	_____	
☐ **Mavyret™** 100mg/40mg (glecaprevir/pilbrentasvir)	Take three tablets (300mg/120mg) PO once daily with food.	4-week supply	_____	
☐ **Ribavirin** Select one: ☐ Generic Ribasphere® ☐ Moderiba™ ☐ RibaPak®	Patient weight: ☐ <75kg: Take 600mg PO QAM and 400mg PO QPM. ☐ ≥75kg: Take 600mg PO twice daily. ☐ Other _____	4-week supply	_____	
☐ **Vosevi™** 400mg/100mg/100mg (sofosbuvir/velpatasvir/voxilaprevir)	Take one tablet PO once daily with food.	4-week supply	_____	
☐ **Zepatier™** 50mg/100mg (elbasvir/grazoprevir)	Take one tablet PO once daily.	4-week supply	_____	
	Baseline NS5A resistance testing is recommended for patients with genotype 1a. The addition of ribavirin may be required for some patient populations.			
☐ Other Medication				
Drug _____	☐ _____	☐ _____	_____	

Please include hard copies of latest H&P, CBC, CMP, genotype, viral load, and liver biopsy/fibrosis assessment.

Another brand of a generically equivalent product, identical in dosage, form, and content of active ingredients, may be dispensed unless initialed d.a.w.
Provider must handwrite "d.a.w." (dispense as written) if product substitution not permitted _____

Provider Signature _____ **Date** _____

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V121919A

CLEAR FORM