ATLANTIC SPECIALTY DRUGS

HEPATITIS C
REFERRAL FORM

Phone: 562-912-7940
Fax: 562-912-7944
4233 Atlantic ave, Long Beach, CA 90807

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx:** ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
Patient SS#: _____ DOB: _____
Allergies: _____
Gender: ❑ Male ❑ Female ❑ See Attached Demographic Allergies: ❑ NKDA ❑ Other

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Insurance: _____
City: _____ State: _____
Plan No: _____ Group No: _____
Phone: _____
Rx Card (PBM): _____
PBM BIN: _____
City: _____ State: _____
Group: _____ Phone: _____

DIAGNOSIS INFORMATION

Diagnosis ICD 10: ❑ B18.2 Hepatitis C (Chronic) ❑ Other _____
Genotype: ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
Baseline Viral Load: _____ Date: _____
Degree of fibrosis: ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4 **Other:** _____
Cirrhosis: ❑ none ❑ compensated ❑ decompensated
Transpant status: ❑ N/A ❑ Pre-transplant ❑ Post-transplant
IL28B: ❑ CC ❑ CT ❑ TT

Patient Type:
❑ naive ❑ relapser ❑ partial responder ❑ null responder
Any prior treatment: ❑ No ❑ Yes (provide information below)
Med: _____ From _____ To _____ Weeks _____
Med: _____ From _____ To _____ Weeks _____
Med: _____ From _____ To _____ Weeks _____
Co-infection(s) : ❑ None ❑ HIV ❑ HBV
Other Comorbidities: _____ Allergies: ❑ NKDA ❑ Other

- **Labs:** to be performed prior to therapy and monitored during treatment at appropriate intervals (particularly pregnancy test for woman of childbearing potential)
  ALT _____ AST _____ Hgb _____ Plt _____
- **Other medications** patient is currently taking (including OTC medications):
  ❑ See Med List _____
- **Other disease states:** ❑ Depression ❑ Anxiety ❑ Diabetes ❑ Other_____

PRESCRIPTION INFORMATION

❑ **HARVONI**® (Ledipasvir/Sofosbuvir) 90 mg/400 mg tablet QD
Quantity: 28 Refill: _____
Anticipated duration: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks ❑ Other _____

❑ **EPCLUSA** (Sofosbuvir and Velpatasvir) 400 mg/100 mg tablet QD
Quantity: 28 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ Other _____

❑ **VIEKIRA PAK** (Ombitasvir, paritaprevir, and ritonavir tablets copackaged with dasabuvir tablets)
Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (am & pm) with a meal.
Quantity: 112 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____

❑ **RIBAVIRIN** ❑ **RIBAPAK** ❑ **MODERIBA** ❑ **OTHER**
Quantity: QS 28 days Refill: _____

Weight (lbs)	Weight (kgs)	Daily Dosage	Directions
		❑ 600 mg	Take 200mg po qAM and 400mg po qPM
		❑ 800 mg	Take 400mg po qAM and 400mg po qPM
❑ 165 & below	< 75	❑ 1000 mg	Take 600mg po qAM and 400mg po qPM
❑ 166 & above	> 75	❑ 1200 mg	Take 600mg po qAM and 600mg po qPM

❑ **SOVALDI** (sofosbuvir) 400 mg tablet QD
Quantity: 28 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____

❑ **DAKLINZA** (daclatasvir)
❑ 60 mg tablet QD Quantity: 28 Refill: _____
❑ 30 mg tablet QD Quantity: 28 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____

❑ **TECHNIVIE** (ombitasvir, paritaprevir, and ritonavir)
Take 2 tablets in the morning with food. Quantity: 56 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ Other _____

❑ **ZEPATIER** (elbasvir and grazoprevir)
Quantity: 28 Refill: _____ Take one tablet by mouth QD
Anticipated duration: ❑ 12 weeks ❑ 16 weeks ❑ Other _____

❑ **OLYSIO** (simeprevir) 150 mg QD
Quantity: 28 Refill: _____
Anticipated duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____

❑ **OTHER** _____
Dosage: _____ Qty: _____ Refills: _____

PRESCRIBER INFORMATION

# of Prescriptions: _____

Physician's Name (Please Print): _____ NPI #: _____
Address: _____ License #: _____
City, State, Zip: _____ DEA #: _____
Phone: _____ Fax: _____ Contact Name: _____
Physician's Signature: _____ Date: _____

I authorize Atlantic Drugs and its representatives to act as an initiate and execute the insurance prior authorization process.

- The prescription form is valid only if faxed directly by the prescriber or his/her authorized representative. Original prescription drug orders can only be accepted directly from patients.
- The prescriber attests that he/she has advised the patient with the option of choosing a pharmacy of his/her choice.