Hepatitis C

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information		Prescriber Information		
Patient Name		Prescriber Name		
Address		DEA#	NPI#	License #
City, State, Zip		Address		
Primary Phone	Emergency Contact Name & Phone Number	City, State, Zip		
Date of Birth ☐ Male ☐ Female		Phone	Fax	
Social Security #		Contact Person		

Insurance Information: Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information: **Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization**

Diagnosis: ☐ B18.2 Chronic Hepatitis C ☐ B17.10 Acute Hepatitis C ☐ K72.90 Hepatic Encephalopathy ☐ C22.0 Liver Cell Carcinoma
Other: ICD code _____ Condition: _____ ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Uncompensated Cirrhosis
Genotype: ☐ 1 ☐ 1a ☐ 1b ☐ 2 ☐ 2a ☐ 2b ☐ 3 ☐ 3a ☐ 3b ☐ 4 ☐ 4a ☐ 4b ☐ 5 ☐ 6 ☐ K58.0 IBS w/Diarrhea
For genotype 1a, is the Q80K polymorphism present? ☐ Yes ☐ No Viral Load: _____ Viral Load Date: _____
Prior Treatment? ☐ Yes ☐ No # of weeks: _____ ☐ Relapsed ☐ Partial Response ☐ Null Response
Liver biopsy done? ☐ Yes ☐ No Date: _____ Result: _____
Allergies: _____ Height: _____ Weight: _____

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
Sovaldi®	☐ 400mg Tablets	☐ 1 tablet by mouth daily with or without food	☐ 4 week supply	_____
Harvoni®	☐ 90mg/400mg Tablets	☐ 1 tablet by mouth daily with or without food	☐ 4 week supply	_____
Viekira Pak®	☐ 12.5mg/75mg/50mg and 250mg	☐ Take 2 pink tablets (ombitasvir/paritaprevir/ritonavir) once daily in the morning and take 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.	☐ 4 week supply	_____
Ribavirin®	☐ 200mg Capsules	☐ 600mg/day - 1 capsule in morning and 2 capsules in evening ☐ 800mg/day - 2 capsules in morning and 2 capsules in evening ☐ 1000mg/day - 3 capsules in morning and 2 capsules in evening ☐ 1200mg/day - 3 capsules in morning and 3 capsules in evening	☐ 4 week supply	_____
Olysio®	☐ 150mg Capsules	☐ Take 1 capsule once a day with food	☐ 4 week supply	_____
Pegasys®	☐ 135mcg Prefilled Syringe ☐ 180mcg Prefilled Syringe ☐ Other	☐ Inject 135mcg Sub-Q once weekly ☐ Inject 180mcg Sub-Q once weekly ☐ Inject 90mcg Sub-Q once weekly	☐ 4 week supply	_____
Peg-Intron®	☐ 50mcg / 0.5ml Redipen	Weight (lbs) < 88 / Weight (kg) < 40: ☐ Inject 50mcg (0.5ml) Sub-Q weekly	☐ 4 week supply	_____
	☐ 80mcg / 0.5ml Redipen	88 - 111 / 40 - 50: ☐ Inject 64mcg (0.4ml) Sub-Q weekly 112 - 133 / 50 - 60: ☐ Inject 80mcg (0.5ml) Sub-Q weekly		
	☐ 120mcg / 0.5ml Redipen	134 - 166 / 61 - 75: ☐ Inject 96mcg (0.4ml) Sub-Q weekly 167 - 187 / 76 - 85: ☐ Inject 120mcg (0.5ml) Sub-Q weekly		
	☐ 150mcg / 0.5ml Redipen	> 187 / > 85: ☐ Inject 150mcg (0.5ml) Sub-Q weekly		
Xifaxan®	☐ 550mg Tablets Starter Pack	☐ Take 1 tablet by mouth 3 times daily	☐ 1 Starter Pack	0
	☐ 550mg Tablets	☐ Take 1 tablet by mouth twice daily	☐ 60 Tablets	_____
☐			☐ 4 week supply	_____

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW _____ Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process.