Home Infusion & Specialty Pharmacy
CHARTWELL
PENNSYLVANIA, LP

Hep C Referral Form

Chartwell Specialty Pharmacy
Telephone: 1-800-366-6020 Fax: 412-920-1869

Auth #: ____________________ **Auth Dates:** ____________________ ☐ **UPMC prior auth form attached**

Patient Information

Date: ____________ Patient SS#: ______________________________ DOB: ____________ ☐ Male ☐ Female

First Name: ______________________________ Last Name: ______________________________

Address: ______________________________ City: ________________ State: ______ Zip: __________

Phone #: ______________________________ Alternate Phone #: ______________________________

Caregiver/ Emergency Contact: ______________________________ Phone #: ______________________________

Weight:________ Allergies: ______________________________ Latex allergy: ☐ Yes ☐ No

Insurance

Primary Insurance: ______________________________

Insured: ______________________________

Phone: ______________________________

Policy: ____________________ Grp #: ____________

Secondary Insurance: ______________________________

Insured: ______________________________

Phone: ______________________________

Policy: ____________________ Grp #: ____________

ICD10

Diagnosis:
☐ B18.2HVC
☐ Other:

Genotype:
☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 6

Viral Load/ Date:
Is member co-infected with HIV? ☐ Yes ☐ No
Is member co-infected with compensated cirrhosis? ☐ Yes ☐ No
Does the patient have a history of receiving treatment? ☐ Yes ☐ No (Naïve) IL28B: ☐ CC ☐ CT ☐ TT
If yes, please indicate medication including dates and dosage:

If yes, please indicate accordingly: ☐ Non-Responder to previous treatment ☐ Partial Responder to previous treatment ☐ Re-lapser after previous treatment

Prescription

Medication	Dose/ Strength	Directions	Quantity	Refills
☐ **Daklinza™ (daclatasvir)**	☐ 30mg ☐ 60mg	Take one tablet by mouth once daily	28 Days (28 tablets)	
☐ **Epclusa™ (velpatasvir 100mg, sofosbuvir 400mg)**	☐ 100mg/ 400 tablet	☐ Take one tablet by mouth once daily for 12 weeks ☐ Take one tablet by mouth for ______ weeks	28 Days (28 tablets)	☐ 2 ☐ _____
☐ **Harvoni™ (ledipasvir 90mg, sofosbuvir 400mg)**	☐ 90mg/400mg tablet	Take one tablet by mouth once daily	28 Days (28 tablets)	
☐ **Mavyret™**	☐ 100mg-40mg	☐ Take 3 tablets by mouth daily	28 Days (84 tablets)	
☐ **Olysio™ (simeprevir)**	☐ 150mg capsule	Take one capsule by mouth once daily with food	28 days (28 capsules)	
☐ **Pegasys™**	☐ 180 mcg/0.5ml prefilled syringe ☐ 180 mcg/10.5ml ProClick	Administer one weekly sub-Q	28 days (4 units)	
☐ **Peg-Intron™**	☐ 120mcg/0.5ml Redipen ☐ 150mcg/0.5ml Redipen	Administer ______mcg one weekly SC	28 days (4 pens)	
☐ **Ribavirin™**	☐ 200mg capsule	Administer by mouth________mg in the morning and _______mg in the evening 2	28 days _____ caps	
☐ **Sovaldi™ (sofosbuvir)**	☐ 400mg tablet	Take one tablet by mouth once daily	28 days (28 tablets)	
☐ **Technivie™**	☐ 40mg/0.8mL pen (2 pens/ box) ☐ 40mg/0.8mL, prefilled syringe (2 syringes/ box)	☐ **Initial Dose:** Inject 160mg SC on day 1, inject 80mg SC on day 15 ☐ **Maintenance Dose:** Inject 40mg SC every other week	☐ 4 week supply	
☐ **Viekira PAK™**	☐ Ombitasivir/Paritaprevir/Ritonavir 12.5mg/75mg/50mg ☐ Dasabuvir 250mg	☐ Take 2 tablets by mouth in the morning ☐ Take 1 tablet by mouth in the morning and one tablet in the evening	28 days (56 tablets)	
☐ **VIEKIRA XR™ (ombitasvir 8.33 mg, paritaprevir 50 mg, ritonavir 33.33 mg, dasabuvir 200 mg)**	☐ 8.33mg/50mg/33.33mg/200mg tablet	Take three tablets by mouth once daily	28 days (84 tablets)	
☐ **Vosevi™ (sofosbuvir 400 mg, velpatasvir 100 mg, voxilaprevir 100 mg)**	☐ sofosbuvir 400 mg/velpatasvir 100 mg/ voxilaprevir 100 mg tablet	Take one tablet by mouth once daily with food	28 days	
☐ **Zepatier™ (elbasvir 50mg, grazoprevir 100mg)**	☐ 50mg/100mg tablet	Take one tablet by mouth once daily	28 days (28 tablets)	

Prescriber Information

Date Shipment Needed: ____________________ Ship to: ☐ Patient ☐ Physician/ Clinic

☐ Ship to other: ______________________________

Physician's Name: ______________________________ Office Contact Name: ______________________________
(please print)

Phone #: ______________________________ Fax #: ______________________________

Address: ______________________________ City: ________________ State: __________ Zip: __________

Physician's Signature: ______________________________ Date: ____________________

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent and execute the insurance prior authorization process.

Updated 10/11/17