PERFORMSPECIALTY®

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Hepatitis C Referral Form

Fax: 1-844-489-9565 | Phone: 1-855-287-7888 | www.performspecialty.com

First ship to: ☐ Patient ☐ Physician **Need by date:**

Patient

Patient name:			
Date of birth:	☐ Male ☐ Female	Height:	Weight: lb kg
Address:		City:	State: ZIP:
Home number:	Work number:	Cell number:	Best time to call: ☐ a.m. ☐ p.m.
Social Security number:		Ethnicity:	
Primary language:	Allergies:		☐ No known drug allergies (NKDA)

Provider

Physician name:		Practice name:	
State license number:		Drug Enforcement Administration (DEA) number:	
Address:	City:	State:	ZIP:
National Provider Identifier (NPI) number:	Phone:	Fax:	
Key office contact name:		Phone:	

Insurance*

Primary insurance:	ID number:	Phone:
Secondary insurance:	ID number:	Phone:
BIN:	PCN:	Group No.:

***Please provide a copy of the insurance card (front and back).**

Clinical information

Diagnosis: ☐ Hepatitis C (ICD:_____)	Genotype* (including subtype): ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6		
*If Genotype 1a: ☐ Without Q80k ☐ With Q80k [Olysio (simeprevir)] ☐ With NS5A RAVs ☐ Without NS5A RAVs [Zepatier (elbasvir/grazoprevir)] ☐ IL28B: ☐ C/C ☐ C/T ☐ T/T Negative Pregnancy Test? (for Ribavirin): ☐ Yes ☐ No ☐ N/A			
Fibrosis: ☐ Yes ☐ No Metavir fibrosis score:			
Hepatocellular carcinoma: ☐ Yes ☐ No If yes, meets Milan criteria: ☐ Yes ☐ No		Liver transplant: ☐ Yes ☐ No Date:	
Baseline HCV-RNA results:		IU / mL date:	
Please submit history and physical, most recent progress notes and/or labs, pathology, and scans.			
Cirrhosis? ☐ No ☐ Compensated ☐ Decompensated		Child-Pugh score (if applicable) ☐ A ☐ B ☐ C	
HIV co-infected: ☐ Yes ☐ No		Hepatitis B co-infected: ☐ Yes, HBsAG___ anti-HBs_____ anti-HBC ☐ No	
Previously treated: ☐ Yes ☐ No If yes, please list therapy:			Dates:
Regimen:	Dates:	☐ Partial ☐ Relapser ☐ Null	
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Prescription information

Medication	Dose/Strength	SIG	Quantity	Refills
☐ Daklinza™	***Baseline therapy*** ☐ 60 mg tablets ***Dose modification therapy*** ☐ 30 mg tablets ☐ 90 mg tablets	Take 1 tablet by mouth once daily with or without food. **(Dose modification: Reduce dosage to 30 mg once daily with strong CYP3A inhibitors and increase dosage to 90 mg once daily with moderate CYP3A inducers)**	28 day supply	
☐ Epclusa®	400 mg/100 mg tablets	Take 1 tablet by mouth once daily with or without food.	28 day supply	
☐ Harvoni®	90 mg / 400 mg tablets	Take 1 tablet by mouth once daily with or without food.	28 day supply	
☐ Mavyret®	100 mg/40 mg tablets	Take 3 tablets by mouth once daily with food	28 day supply	
☐ Vosevi®	400 mg/100 mg/100 mg tablets	Take 1 tablet by mouth once daily with food	28 day supply	
☐ Zepatier™	50 mg/100 mg tablets	Take 1 tablet by mouth once daily with or without food.	28 day supply	
☐ Ribavirin	200mg ☐ Tablets ☐ Capsules	Take _____By mouth in the morning and take _____By mouth in the evening with food. Total Daily Dose: ☐400mg ☐600mg ☐800mg ☐1000mg ☐1200mg	28 day supply	
☐ Other				

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS. (STAMPS NOT ACCEPTED)

Prescriber Signature:	Prescriber Signature:
☐ Dispense as written/Do not substitute Date:	☐ Substitution permitted/Branded exchange permitted Date:

For states requiring handwritten expressions of product selection, use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).