Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Hepatitis C Referral Form

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Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name ______ DOB ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Daytime Tel ______ Evening Tel ______ Cell ______ Email ______ Date Needed ______
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy ☐ Fibrosure ☐ Fibrotest Results ______
ICD-10 Diagnosis ______ Biospsy ☐ Yes ☐ No Results ______ Previously treated ☐ Yes ☐ No If yes, what drugs ______
HCV MEDICAL CRITERIA Genotype ______ HCV-Viral Load ______ (IU) Date of Labs ______ ALT ______ AST ______ Hgb ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______
Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ VIEKIRA

QTY 28 Day Supply Refill x ____
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) and Dasabuvir 250 mg tab (beige)
Directions: Take 2 pink tablets PO once daily (AM) with food and one beige tablet PO twice daily (AM and PM) with food

Treatment Regimen and Duration by Patient Population

Patient Population	Treatment*	Duration
Genotype 1a, without cirrhosis	VIEKIRA PAK + ribavirin	12 weeks
Genotype 1a, with cirrhosis	VIEKIRA PAK + ribavirin	24 weeks**
Genotype 1b, without cirrhosis	VIEKIRA PAK	12 weeks
Genotype 1b, with cirrhosis	VIEKIRA PAK + ribavirin	12 weeks

*Note: Follow the genotype 1a dosing recommendations in patients with an unknown genotype 1 subtype or with mixed genotype 1 infection.
**VIEKIRA PAK administered with ribavirin for 12 weeks may be considered for some patients based on prior treatment history

OLYSIO (Simeprevir)

☐ 150mg cap Qty:____ Refill:____
Directions: Take 1 capsule by mouth with food daily for 12 weeks with peginterferon and ribavirin

☐ TECHNIVIE

Genotype 4 ONLY
paritaprevir/ritonavir (75/50 mg) and ombitasvir (12.5 mg)
SIG: two tablets QAM with a meal and along with RIBAVIRIN
Qty:____ Refill:____

☐ RIBAVIRIN

200mg tablet SIG: take 1 tablet twice a day
Qty:____ Refill:____

☐ RIBAPAK ☐ MODARIBA

- ☐ Ribapak 600mg PO Daily; 200mg QAM, 400mg QPM
- ☐ Ribapak 800mg PO Daily; 400mg QAM, 400mg QPM
- ☐ Ribapak 1000mg PO Daily; 600mg QAM, 400mg QPM
- ☐ Ribapak 1200mg PO Daily; 600mg QAM, 600mg QPM
- ☐ Ribavirin 200mg Sig ______

QTY____ Refills ____

☐ HARVONI

Ledipasvir 90mg / Sofosbuvir 400mg
- ☐ 12 weeks treatment-naïve with or without cirrhosis
- ☐ 12 weeks treatment-experienced without cirrhosis
- ☐ 24 weeks treatment-experienced with cirrhosis
- ☐ 8 weeks treatment (can be considered) in naïve patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

SIG: Take 1 tablet by mouth daily QTY ____ Refill x ____

DAKLINZA (daclatasvir)

Genotype 3 only
- ☐ 30 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: ____
- ☐ 60 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: ____

SIG: take 1 tablet each daily Total daily dose:____

PEGASYS

QTY: ☐ 1 month ☐ 3 month Refill x ______
- ☐ ProClick **135mcg Autoinjector** (NDC 004-0365-30) Inject SQ weekly
- ☐ ProClick **180mcg Autoinjector** (NDC 004-0365-30) Inject SQ weekly
- ☐ **Pre-Filled Syringe180mcg/0.5ml** (NDC 004-0357-30) Inject SQ weekly
- ☐ Other ______

SOVALDI (Sofosbuvir) 400mg tablet

Take 1 tablet by mouth daily for:
- ☐ 12 weeks w/ Ribapak and peginterferon (Geno 1 or 4)
- ☐ 24 weeks with Ribapak (Genotype 1 or 4)
- ☐ 12 weeks with Ribapak (Genotype 2)
- ☐ 24 weeks with Ribapak (Genotype 3)

QTY____ Refills ____

OTHER

______ Strength ______
Qty ______ Refill x ____ Months
SIG: ______

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

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