



Hepatitis C Referral Form

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Surescripts ID #: CPR10785350213549930
Office: 1-888-292-0744
Fax Referral #: 1-800-269-5493

Referral Info

PATIENT INFORMATION

Patient's Name:		SSN:	DOB:	
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female
Email Address:		Diagnosis Code:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Phone:	Policy #:	Group #:
Secondary Insurance:	Phone:	Policy #:	Group #:

CLINICAL INFORMATION

Responder status: <input type="checkbox"/> Treatment Naïve <input type="checkbox"/> Treatment Experienced Prior Treatment Type: _____ _____ Did patient fail NS5A based treatment (Harvoni, Daklinza, Viekira, Zepatier)? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please include RAV)	Comorbidities: <input type="checkbox"/> ESRD <input type="checkbox"/> HIV <input type="checkbox"/> HBV <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____ Fibrosis Stage: _____ Child-PugScore: _____	HCV genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 1a <input type="checkbox"/> 2a <input type="checkbox"/> 3a <input type="checkbox"/> 4a <input type="checkbox"/> 1b <input type="checkbox"/> 2b <input type="checkbox"/> 3b <input type="checkbox"/> 4b <input type="checkbox"/> Other _____ HCV RNA: _____ Cirrhosis: <input type="checkbox"/> Y <input type="checkbox"/> N If YES: <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated
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Test Type	GT1 NS5A RAV Test	Genotype + GT1a RAV (reflex) panel	Viral Load + GT1a RAV (reflex) panel	Viral Load + Genotype (reflex) + GT1a RAV (reflex) panel
Quest Lab	92447(X)	93871(X)	N/A	93873(X)
LabCorp	550325	550615	93873(X)	550705

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	SIG/ DIRECTIONS:	QUANTITY	REFILLS
<input type="checkbox"/> MAVYRET™ (glecaprevir/ pibrentasvir)	Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food	28 Day Supply	
<input type="checkbox"/> HARVONI® (ledipasvir 90 mg/ sofosbuvir 400 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> EPCLUSA® (sofosbuvir 400 mg/ velpatasvir 100 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> VOSEVI™ (sofosbuvir 400 mg/ velpatasvir 100 mg)	One tablet taken by mouth once daily with food.	28 Day Supply	
<input type="checkbox"/> ZEPATIER® (elbasvir 50 mg/ grazoprevir 100 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> RIBAVIRIN® 200 mg	_____ mg AM _____ mg PM	28 Day Supply	
<input type="checkbox"/> Other			

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

Dispense as written

PHYSICIAN INFORMATION

Injection Training: Office to Instruct SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office
NPI #:	Tax ID #:	
Prescriber Signature:	Date:	

Your signature authorizes BioPlus Specialty Pharmacy Services, Inc., and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the "BioPlus Pharmacies"), to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copy and financial assistance on behalf of your patients.

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
MedScripts Medical Pharmacy 1325 Miller Rd. Suite K, Greenville, SC 29607 **River Medical Pharmacy** 4752 Research Drive, San Antonio, TX 78240
Route 300 Pharmacy 1208 Route 300 Suite 103, Newburgh, NY 12550

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