

Patient Name _____ SS# _____ DOB _____ Male Female
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
 Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

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# _____

Previously treated No Yes, what drugs _____ Interferon Yes No # of Weeks _____
 ICD-10 Code B18.2 HCV (Chronic) B19.2 F Score _____ relapsed partial response null response
 Cirrhosis Yes No Compensated Decompensated
 HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

<input type="checkbox"/> MAVYRET 100 mg glecaprevir / 40 mg pibrentasvir tablet SIG: <input type="checkbox"/> Take 3 tablets by mouth daily with food Qty: 84 Refills: _____ <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____	<input type="checkbox"/> SOVALDI (Sofosbuvir) 400mg tablet SIG: Take 1 tablet by mouth daily Qty: 28 Refills: _____
<input type="checkbox"/> VOSEVI 400 mg sofosbuvir / 100 mg velpatasvir / 100 mg voxilaprevir tablet SIG: <input type="checkbox"/> Take 1 tablet by mouth daily for 12 weeks Qty: _____ Refills: _____ <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____	<input type="checkbox"/> ZEPATIER Grazoprevir 100mg/ Elbasvir 50mg tablet SIG: Take one tablet by mouth daily Qty: 28 Refills: _____
<input type="checkbox"/> EPLCUSA Sofosbuvir 400 mg / Velpatasvir 100 mg tablet SIG: <input type="checkbox"/> Take 1 tablet by mouth daily for 12 weeks <input type="checkbox"/> Take 1 tablet by mouth daily for 12 weeks WITH Ribavirin QTY: 28 Refills: _____	<input type="checkbox"/> PEG INTRON <input type="checkbox"/> REDIPEN <input type="checkbox"/> VIAL Strength (Dose) <input type="checkbox"/> 50mcg/0.5ml <input type="checkbox"/> 120mcg/0.5ml <input type="checkbox"/> 80mcg/0.5ml <input type="checkbox"/> 150mcg/0.5ml Directions _____ Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months Refills: _____
<input type="checkbox"/> HARVONI Ledipasvir 90mg / Sofosbuvir 400mg tablet SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____	<input type="checkbox"/> PEGASYS <input type="checkbox"/> ProClick 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly <input type="checkbox"/> Pre-Filled Syringe 180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly <input type="checkbox"/> Other _____ Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months Refills: _____
<input type="checkbox"/> DAKLINZA <input type="checkbox"/> 30 mg / <input type="checkbox"/> 400 mg SOVALDI Qty: 28 Refills: _____ <input type="checkbox"/> 60 mg / <input type="checkbox"/> 400 mg SOVALDI Qty: 28 Refills: _____ <input type="checkbox"/> 90 mg / <input type="checkbox"/> 400 mg SOVALDI Qty: 28 Refills: _____ SIG: take 1 tablet each daily Total daily dose: _____ GT3 ONLY	<input type="checkbox"/> VIEKIRA XR Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg SIG: Take 3 tablets PO QAM with meal for: <input type="checkbox"/> 12 weeks w/ Ribavirin (GT 1a, w/o cirrhosis) <input type="checkbox"/> 24 weeks w/ Ribavirin (GT 1a, w/ compensated cirrhosis) <input type="checkbox"/> 12 weeks (GT 1b, w/ or w/o compensated cirrhosis) Qty: 84 Refills: _____
<input type="checkbox"/> RIBAVIRIN <input type="checkbox"/> MODERIBA <input type="checkbox"/> RIBAPAK <input type="checkbox"/> 600mg PO Daily; 200mg QAM, 400mg QPM <input type="checkbox"/> 800mg PO Daily; 400mg QAM, 400mg QPM <input type="checkbox"/> 1000mg PO Daily; 600mg QAM, 400mg QPM <input type="checkbox"/> 1200mg PO Daily; 600mg QAM, 600mg QPM <input type="checkbox"/> Other 200mg Sig _____ Qty: 28 Day Supply Refills: _____	<input type="checkbox"/> VIEKIRA PAK _____ QTY: 112 Refills: _____ Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige) Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food
<input type="checkbox"/> TECHNIVIE paritaprevir / ritonavir (75/50 mg) and ombitasvir (12.5 mg) SIG: two tablets QAM with meal and with <input type="checkbox"/> RIBAVIRIN Qty: 28 Day Supply Refills: _____ GT4 ONLY	<input type="checkbox"/> NEUPOGEN <input type="checkbox"/> 300 mcg <input type="checkbox"/> 480mcg Sig _____ Qty: _____ Refills: _____ <input type="checkbox"/> PROCRIT Sig _____ Qty: _____ Refills: _____
<input type="checkbox"/> OLYSIO 150mg capsule Qty: 28 Refills: _____ SIG: Take 1 capsule by mouth daily for 12 wks w/ peginterferon and ribavirin	<input type="checkbox"/> OTHER _____ Qty: _____ Refills: _____ Sig _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care 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** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

NEW REFERRAL CHECKLIST FOR HEPATITIS C MEDICAID PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. Most Medicaid plans require the following lab values obtained within the last 3 months.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- | | |
|---|--|
| <input type="checkbox"/> Albumin | <input type="checkbox"/> HIV serology (CD4 + T-cell count and HIV RNA) |
| <input type="checkbox"/> ANA | <input type="checkbox"/> Iron study |
| <input type="checkbox"/> Bilirubin (direct and total) | <input type="checkbox"/> LFTs |
| <input type="checkbox"/> Blood alcohol level | <input type="checkbox"/> Liver biopsy/Fibroscan (preferred)/ARFI |
| <input type="checkbox"/> CBC with diff | <input type="checkbox"/> NS5A Lab (required for Zepatier 1a patients) |
| <input type="checkbox"/> Child- Pugh score if available | <input type="checkbox"/> Pregnancy test (for women of child bearing age) |
| <input type="checkbox"/> Cirrhosis (decompensated or compensated) | <input type="checkbox"/> PT/INR |
| <input type="checkbox"/> ECG (if heart disease present) | <input type="checkbox"/> Serum HBsAg, anti-HBc, anti-HBs, anti-HAV |
| <input type="checkbox"/> Genotype | <input type="checkbox"/> Serum creatinine |
| <input type="checkbox"/> GFR | <input type="checkbox"/> Stage of fibrosis ____ |
| <input type="checkbox"/> Glucose | <input type="checkbox"/> TSH |
| <input type="checkbox"/> HCV RNA (viral load) | <input type="checkbox"/> Uric acid |
| | <input type="checkbox"/> Urine drug screen |

THE FOLLOWING CLINICAL INFORMATION IS REQUIRED IN ADDITION TO THE ABOVE LAB WORK

- Patient should be enrolled in the Health Plan's Hepatitis C Adherence program if applicable
- Psychiatric history and clearance to start therapy
- Clinical finding of extrahepatic manifestations or cirrhosis
- If patient has a drug/alcohol history, clinical notes are needed documenting abstinence from illicit drugs and alcohol for at least 6 months
- Previous treatment regimen: _____
- Dates of previous treatment: _____
- Previous treatment outcome: Non-responder, partial responder, relapse, discontinued
- Reason for discontinuation: _____
- Documentation that patient agrees to use 2 or more forms of contraception and will have monthly pregnancy test
- Documentation of liver transplant or hepatocellular carcinoma if applicable
- Complete medical history and medication list

Fax the requested documentation to (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

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SPECIALTY CARE
A BIOMATRIX^{SpRx} Company

