aleracare
advanced specialty pharmacy

Hepatology
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height:	Weight:	Allergies:	Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Genotype ◯ 1a ◯ 1b ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 Tx naïve? ◯ Y ◯ N Cirrhosis ◯ Y ◯ N Fibrosis ◯ F1 ◯ F2 ◯ F3 ◯ F4

Hep C Medication	Directions for Use	Qty	Refills
◯ **EPCLUSA®** (Sobosbuvir / Velpatasvir)	◯ Take 1 tablet by mouth daily	#28	
◯ **HARVONI®** (Sobosbuvir / Ledipasvir)	◯ Take 1 tablet by mouth daily	#28	
◯ **MAVYRET®** (Glecaprevir / Pibrentasvir)	◯ Take 1 tablet by mouth daily	#28	
◯ **VOSEVI®** (Sofosbuvir / Velpatasvir / Voxilaprevir)	◯ Take 3 tablet by mouth daily ***with food***	#28	
◯ **ZEPATIER®** (Elbasvir / Grazoprevir)	◯ Take 1 tablet by mouth daily	#28	
◯ **RIBAVIRIN** ◯ **MODERIBA** ◯ **RIBAPACK**	◯ Take 200mg PO QAM & 400mg PO QPM ◯ Take 400mg PO QAM & 400mg PO QPM ◯ < 75kg Take 600mg PO QAM & 400mg PO QPM ◯ > 75kg Take 600mg PO QAM & 600 PO QPM	#84 #112 #140 #168	

Hep B Medication	Strength	Directions for Use	Qty	Refills
◯ **BARACLUDE®**	◯ 0.5mg ◯ 1mg ◯ 0.05mg/ml:	◯ 0.5mg tab PO daily (Naïve pt or adolescents ≥ 16 yo) ◯ 1mg tab PO daily (Lamivudine -Refractory pt) ◯ 0.05mg/ml ◯ Dose adjustment by Creatinine Clearance (if less than 50ml/min):	#30	
◯ **EPIVIR HBV®**	◯ 100mg	◯ 100 mg by mouth daily	#30	
◯ **HEPSERA®**	◯ 10mg	◯ 100mg PO daily ◯ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	#30	
◯ **HBIG®** Hepatitis B Immune Globulin - single use vial		◯ 5ml IM in 2 divided doses, every ◯ 2ml IM in 2 divided doses, every ◯ 10,000 International Units(32ml) in 250ml NS, IV over _____hour(s), every _____for _____infusions ◯ Alternative Dosage: _____		
◯ **PEGASYS®** ◯ Prefilled Syringe ◯ Vial ◯ ProClick®	◯ 180mcg ◯ 135mcg	◯ 90mcg SQ once weekly ◯ 180mcg SQ once weekly ◯ 135mcg SQ once weekly	#28	
◯ **TYZEKA®**	◯ 600mg	◯ 600mg by mouth daily ◯ Dose adjustment by Creatinine Clearance (if less than 50ml/min)	#30	
◯ **VEMLIDY®**	◯ 25mg	◯ 25mg by mouth daily with food	#30	
◯ **VIREAD®**	◯ 300mg	◯ 300mg PO daily ◯ Dose adjustment by Creatinine Clearance (if less than 50ml/min):	#30	

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**