HEPATITIS C REFERRAL FORM

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Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Daklinza (daclatasvir)	☐ 30mg Tablet	Take 1 tablet by mouth once daily.	28	
	☐ 60mg Tablet			
	☐ 90mg Tablet			
☐ Epclusa (sofosbuvir/velpatasvir)	400/100mg Tablet	Take 1 tablet by mouth once daily.	28	
☐ Harvoni (ledipasvir/sofosbuvir)	90/400mg Tablet	Take 1 tablet by mouth once daily.	28	
☐ Mavyret (glecaprevir/pibrentasvir)	100/40mg Tablet	Take 3 tablets by mouth once daily with food.	84 (28-day supply)	
☐ Ribavirin	☐ 200mg Tablet	☐ <75kg: Take 600mg by mouth in the morning and 400mg by mouth in the evening.	140 (28-day supply)	
	☐ 200mg Capsule	☐ ≥75kg: Take 600mg by mouth in the morning and 600mg by mouth in the evening.	168 (28-day supply)	
		Other:		
☐ Sovaldi (sofosbuvir)	400mg Tablet	Take 1 tablet by mouth once daily.	28	
☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	400/100/100mg Tablet	Take 1 tablet by mouth once daily with food.	28	
☐ Zepatier (elbasvir/grazoprevir)	50/100mg Tablet	Take 1 tablet by mouth once daily.	28	
Other Medication Name:				

Prescription information continued on next page

Treatment History: ☐ **Treatment Naive** ☐ **Non-Response** ☐ **Null-Response** ☐ **Partial-Response** ☐ **Relapsed**

Prescription Information - Continued

Co-infection(s)

☐ HIV

☐ Other _____

Hepatitis B Screening Results:

☐ HBsAg:

☐ Anti-HBs:

☐ Anti-HBc:

Fibrosis Score

☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Cirrhosis Status

☐ None ☐ Compensated ☐ Decompensated - CTP Class

HCV RNA Level_____1u/ml Date Drawn_____

Polymorphisms (if applicable)_____

Duration of Current Treatment

☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other:_____weeks

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name:_____

Group or Hospital:_____ Phone: _____

Fax: _____ Email Address: _____

Address:_____ City: _____ State: _____ Zip: _____

Prescriber Signature:

_____ Product Substitution Permitted _____ Date _____ Dispensed as Written _____ Date

Delivery Information

Ship to: ☐ Patient

☐ Prescriber/Clinic

☐ Pick up at an Albertsons Companies Pharmacy

Address: _____

Phone: _____

Date Medication Needed: _____

It's as simple as **caring.**

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E-Scribe Information:
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