Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
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Hepatitis C Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑B18.2 Hepatitis C (Chronic) ❑Other ICD-10 _____
Genotype:_____
Pre-treatment Viral Load:_____
Collection Date:_____
Co-infected with: ❑HIV ❑HepB ❑N/A

Cirrhosis
❑Compensated
❑Decompensated
❑Hepatocellular carcinoma
❑Post Liver Transplant
Patient's Grade/Child-Pugh score:_____
Fibroscan™? ❑Yes ❑No Results:_____kPa
History of liver biopsy? ❑Yes ❑No ❑N/A
History of liver test? ❑Yes ❑No ❑N/A
Fibrosis present? ❑Yes ❑No ❑F3 ❑F4
Fibro score: ❑N/A

Prior Treatment
Has the patient been previously treated for Hepatitis C? ❑Yes ❑No
If yes, name the product(s), date range(s) and response/outcome (none,partial, full remission, recurrence/relapse).
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Product:_____ Date Range:_____ to _____ Response/outcome:_____
Does patient have any contraindications or intolerances to any Hepatitis C medications? ❑Yes ❑No
If yes, please name medication and describe reaction?_____

Labs: *to be performed prior to therapy and monitored during treatment at appropriate intervals*
ALT:_____Date:_____ AST:_____Date:_____
Hgb _____Date:_____ Platelet:_____Date:_____
Albumin_____Date:_____Serum creatinine:_____ Date:_____
Pregnancy (if appropriate):_____ Date:_____
Other disease states: Depression: _____ Anxiety _____ Diabetes: _____
Other medications (including OTC): *please attach list ifnecessary*_____

NS5A resistant polymorphisms? ❑ Yes ❑No

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Daklinza® (daclatasvir)	❑ 60mg tablet ❑ 30mg tablet	❑ Take one tablet PO once daily with Sovaldi Duration: ❑ 12 weeks ❑24 weeks ❑ Other_____	28	
Epclusa® (sofosbuvir/velpatasvir)	❑ 400mg/100mg tablet	❑ Take one tablet PO once daily Duration: ❑ 12 weeks ❑ Other_____	28	
Harvoni® (ledipasvir/sofosbuvir)	❑ 90mg/400mg tablet	❑ Take one tablet PO once daily ❑ Other:_____ Duration: ❑ 8 weeks ❑12 weeks ❑ 24 weeks ❑ _____	28	
Olysio® (simeprevir)	❑ 150mg capsule	❑ Take one tablet PO once daily with food Duration: ❑ 12 weeks ❑24 weeks	28	
Sovaldi® (sofosbuvir)	❑ 400mg tablet	❑ Take one tablet PO once daily ❑ Other:_____ Duration: ❑ 12 weeks ❑24 weeks ❑_____	28	
Technivie™ (ombitasvir, paritaprevir, ritonavir)	❑ 12.5/75/50mg tablet	❑ Take 2 tablets PO every morning with food Duration: ❑ 12 weeks ❑24 weeks ❑Other_____	56 tablets	
Viekira Pak® (dasabuvir/ombitasvir/paritaprevir/ritonavir)	❑ 250/12.5/75/50mg tablet	❑ Take 3 tablets PO in the morning and 1 tablet PO in the evening with food. Duration: ❑ 12 weeks ❑24 weeks ❑Other_____	112 tablets	
Viekira XR™ (dasabuvir/ombitasvir/paritaprevir/ritonavir)	❑ 200/8.33/50/33.33mg tablet	❑ Take 3 tablets PO once daily with food. Duration: ❑ 12 weeks ❑24 weeks ❑Other_____	84 tablets	
Zepatier™ (elbasvir/grazoprevir)	❑ 50mg /100mg	❑ Take one tablet PO once daily ❑ Other:_____ Duration: ❑ 12 weeks ❑16 weeks ❑Other_____	28	
Riba-Pak® (ribavirin)	❑ 600mg/day (200mg/400mg) ❑ 800mg/day (400mg/400mg) ❑ 1000mg/day (600mg/400mg) ❑ 1200mg/day (600mg/600mg)	❑ Take 200mg tablet PO QAM & 400mg tablet QPM=600mg/day ❑ Take 400mg tablet PO QAM & 400mg tablet QPM=800mg/day ❑ Take 600mg tablet PO QAM & 400mg tablet QPM=1000mg/day ❑ Take 600mg tablet PO QAM & 600mg tablet QPM=1200mg/day	❑ 1-month ❑ 3-month	
Ribavirin	❑ 200mg tablets ❑ 200mg capsules	❑ Take _____ tabs/caps QAM & _____tabs/caps QPM with food. ❑ Other:_____	Qty:_____	
Pegasys® (peginterferon alfa-2a) injection	❑ 135mcg/0.5mL ProClick™ ❑ 180mcg/0.5mLProclick™ ❑ 180mcg/0.5mL PFS kit of 4	❑ Inject 135mcg SC once weekly ❑ Inject 180mcg SC once weekly ❑ Other:_____	4 doses	
Other	❑ _____	❑ _____		
Other	❑ _____	❑ _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payors, processors and other entities.*

Prescriber's Signature: _____Date_____