BIOMATRIX SpRx

HEPATITIS C REFERRAL FORM

TODAY'S DATE ________________

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ** TEL: 877-567-8087 FAX: 877-567-8089
☐ **BiologicTx - CA** TEL: 800-404-1963 FAX: 800-404-4595
☐ **BiologicTx - IL** TEL: 888-892-7607 FAX: 877-567-8089
☐ **Decillion Healthcare** TEL: 800-622-9321 FAX: 866-548-8849
☐ **Elwyn Specialty Care** TEL: 855-359-9679 FAX: 610-545-6030
☐ **Factor Support Network** TEL: 877-376-4968 FAX: 805-482-6324
☐ **Matrix Health** TEL: 877-337-3002 FAX: 888-385-2805
☐ **Med Center Specialty Pharmacy** TEL: 855-633-5633 FAX: 304-344-0655
☐ **MedEx BioCare** TEL: 800-962-6339 FAX: 901-382-3091

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	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

	#		#		#
☐	#	☐	#	☐	#
☐	#	☐	#	☐	#
☐	#	☐	#	☐	#

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# __________

ICD-10 Code ☐ B18.2 HCV (Chronic) ☐ B19.2 F Score________ ☐ relapsed ☐ partial response ☐ null response
Previously treated ☐ No ☐ Yes, what drugs __________ Interferon ☐ Yes ☐ No # of Weeks ______
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

☐ **MAVYRET** Glecaprevir 100 mg / Pibrentasvir 40 mg tablet
SIG: ☐ Take 3 tablets by mouth daily with food QTY: 84 Refills: _____
☐ Other:__________ QTY:_____ Refills: _____

☐ **VOSEVI** Sofosbuvir 400 mg / Velpatasvir 100 mg / Voxilaprevir 100 mg tablet
SIG: ☐ Take 1 tablet by mouth daily for 12 weeks QTY:_____ Refills: _____
☐ Other:__________ QTY:_____ Refills: _____

☐ **EPCLUSA** Sofosbuvir 400 mg / Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tablet by mouth daily for 12 weeks
☐ Take 1 tablet by mouth daily for 12 weeks WITH Ribavirin
QTY: 28 Refills: _______

☐ **HARVONI** Ledipasvir 90 mg / Sofosbuvir 400 mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _______

DAKLINZA ☐ 30 mg / ☐ 400 mg SOVALDI QTY: 28 Refills: _______
☐ 60 mg / ☐ 400 mg SOVALDI QTY: 28 Refills: _______
☐ 90 mg / ☐ 400 mg SOVALDI QTY: 28 Refills: _______
SIG: take 1 tablet each daily Total daily dose:______ GT3 ONLY

☐ **RIBAVIRIN** ☐ **MODERIBA** ☐ **RIBAPAK**
☐ 600mg PO Daily; 200mg QAM, 400mg QPM
☐ 800mg PO Daily; 400mg QAM, 400mg QPM
☐ 1000mg PO Daily; 600mg QAM, 400mg QPM
☐ 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ Other 200mg Sig __________
QTY: 28 Day Supply Refills: _______

☐ **OLYSIO** 150 mg capsule
SIG: Take 1 capsule by mouth daily for 12 weeks with peginterferon and ribavirin
QTY: 28 Refills: _______

☐ **SOVALDI** Sofosbuvir 400 mg tablet
SIG: Take one tablet by mouth daily QTY: 28 Refills: ______

☐ **ZEPATIER** Grazoprevir 100 mg/ Elbasvir 50 mg tablet
SIG: Take one tablet by mouth daily QTY: 28 Refills: ______

PEG INTRON ☐ REDIPEN ☐ VIAL
Strength (Dose) ☐ 50 mcg/0.5ml ☐ 120 mcg/0.5ml
☐ 80 mcg/0.5ml ☐ 150 mcg/0.5ml
Directions: __________
QTY: ☐ 1 month ☐ 3 months Refills: ______

PEGASYS
☐ **ProClick** 180 mcg Autoinjector (NDC 004-0365-30)
Inject subcutaneously weekly
☐ **Pre-Filled Syringe** 180 mcg/0.5ml (NDC 004-0357-30)
Inject subcutaneously weekly
☐ Other __________
QTY: ☐ 1 month ☐ 3 months Refills: ______

☐ **VIEKIRA PAK**
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige)
Directions: Take two pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food
QTY: 112 Refills: ______

NEUPOGEN ☐ 300 mcg ☐ 480 mcg
Sig: __________ QTY:______ Refills: ______

PROCRIT
Sig: __________ QTY:______ Refills: ______

OTHER __________
Sig: __________
QTY:______ Refills: ______

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)______ *Dispense as written* ______ **Date**__________
Prescriber's Signature (signature required. NO STAMPS)______ *Product Substition Permitted* ______ **Date**__________

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Please visit **WWW.BIOMATRIXSPRX.COM** For more information

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NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR HEPATITIS C 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. All lab reports (or EMR) must contain the following information within the last 30 days.

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

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc...)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills and planned treatment duration
- ☐ MD signature and date on referral form

CLINICAL INFORMATION: PREFERABLY, LABS AND TEST RESULTS SHOULD BE WITHIN 8-12 WEEKS OF THE DATE ON THE REFERRAL:

- ☐ Patient weight
- ☐ Genotype (hard copy from lab)
- ☐ HCV RNA (Viral load)
- ☐ Lab results with CBC, ALT/AST, HGB, INR, HFP AND GFR
- ☐ NS5A Lab (required for Zepatier 1a patients)
- ☐ Liver biopsy/Metavir/FibroSure lab
  (Most plans are still requiring stage 3 – 4 fibrosis, but others simply need to see some form of test)
- ☐ Has patient had a liver transplant
- ☐ Is the patient co-infected HIV/Hep C?
- ☐ Previous treatment with medications, dates, and outcome
- ☐ Drug/alcohol test (if applicable)

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