UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

HEPATITIS C REFERRAL

PATIENT INFORMATION

Please send a copy of ALL of patient's Prescription, Primary and Secondary insurance cards (both sides)
Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name ____________________ **DOB** __________ **Gender** ☐ Male ☐ Female

Address____________________ **City**__________ **State** ______ **Zip** ______

Home Phone __________ **Cell Phone** __________ **Work phone** __________ **Email** __________

Primary Language ☐ English ☐ Spanish ☐ Other specify __________ **Allergies** ____________________

RX Member ID __________ **RX Group ID** __________ **RX PCN** __________ **RX BIN**__________

DIAGNOSIS

☐ B18.2 Chronic hepatitis C

☐ Other:____________________ ICD-10 Code(s):__________

PATIENT HISTORY

Does the patient have a history of noncompliance? ☐ No ☐ Yes: Please provide documentation that compliance has been addressed with the patient.

Does the patient have a history of drug and/or alcohol abuse? ☐ No ☐ Yes: Please provide negative urine drug and/or alcohol screen within the past 90 days
Many insurance companies and Medicaid require urine screens for patients with a history of abuse.

Have the patient's current medications been evaluated for drug interactions with the medication(s) prescribed? ☐ No ☐ Yes
Please note changes if needed to avoid drug interactions.

CLINICAL INFORMATION: PLEASE SUBMIT SUPPORTING DOCUMENTATION

HCV Genotype:__________ Pre-treatment HCV RNA viral load:__________IU/ML Collection Date:__________

Serum Creatinine:______ Is the patient receiving Dialysis? ☐ No ☐ Yes Collection Date:______ Height:______ Weight:______

Cirrhosis: ☐ No ☐ Yes Compensated ☐ Yes Decompensated Hepatic Carcinoma: ☐ No ☐ Yes Liver transplant: ☐ No ☐ Yes Date:______

Does the patient have moderate or severe hepatic impairment (Child Pugh Class B and C)? ☐ No ☐ Yes Fibrosis Score:__________

Previous therapy history: ☐Naïve ☐ Relapsed ☐ Non Responder ☐ Null NS5A resistance testing: ☐ Present ☐ Absent

Previous HCV medications (including dates received):____________________

HBV history: ☐ Negative ☐ Positive Treatment (including dates):____________________
Hepatitis B vaccine series complete? ☐ No ☐ Yes Dates provided: ____________________

HIV history: ☐ Negative ☐ Positive Treatment (including dates):____________________

Comorbidities:____________________

PROVIDED PATIENT COUNSELING ON: (CHECK ALL THAT APPLY)

☐ Compliance ☐ HCV Transmission ☐ Precautions to take while HCV positive ☐ HCV Prevention ☐ Other: __________

PRESCRIPTION

Medication:__________ Frequency:______ Route: ______ Qty:______ Refills: ______

Medication:__________ Frequency:______ Route: ______ Qty:______ Refills: ______

Medication:__________ Frequency:______ Route: ______ Qty:______ Refills: ______

Prescriber's Signature:____________________ NPI:__________ Phone:__________

Address: ____________________ City: __________ State:______ Fax:__________