HCV PRESCRIPTION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ________ ❑Male ❑Female SS#: ________ DOB: ________
Address: ________ City, State, Zip: ________
Primary Phone: ________ ❑Home ❑Cell ❑Work Alternate Phone: ________ ❑Home ❑Cell ❑Work
Email: ________ Height: ________ Weight: ________
Allergies: ________ Comorbidities: ________

PRESCRIBER INFORMATION

Prescriber Name: ________ Office Contact: ________
Address: ________ City, State, Zip: ________
Phone: ________ Fax: ________
NPI: ________ DEA: ________

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: ________
Date Shipment Needed By: ________ ❑Alternate Location: ________
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis: ❑B18.2 Chronic Viral Hepatitis C ❑Other ICD-10: ________ Genotype/Subtype: ________ / ________
Patient type: ❑naive ❑relapser ❑partial responder ❑null responder For genotype 1a, is the Q80K polymorphism present? ❑yes ❑no
Cirrhosis: (❑yes ❑no) if yes, is it: ❑compensated ❑decompensated Baseline Viral Load: ________ IU/mL
Metavir score: ❑F0 ❑F1 ❑F2 ❑F3 ❑F4 Fibroscan™: ________ kPa FibroSURE™: ________
Activity: ❑A0 ❑A1 ❑A2 ❑A3 Is the patient awaiting liver transplantation for hepatocellular carcinoma? ❑yes ❑no
Child Pugh Score: ❑A ❑B ❑C Is the patient interferon-intolerant? ❑yes ❑no

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
❑Epclusa® (sofosbuvir/velpatasvir)	400 / 100 mg	28		Take 1 tablet by mouth daily, with or without food
❑Harvoni® (ledipasivir/sofosbuvir)	90 / 400 mg	28		Take 1 tablet by mouth daily with or without food
❑Mavyret® (glecaprevir/pibrentasvir)	100 / 40 mg	84		Take 3 tablets by mouth daily
❑Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)	400 / 100 / 100 mg	28		Take 1 tablet by mouth daily
❑Zepatier® (grazoprevir/elbasvir)	100 / 50 mg	28		Take 1 tablet by mouth daily
❑Other:				

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissable - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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