BARNEY'S PHARMACY
2604 PEACH ORCHARD RD.
AUGUSTA, GA, 30906
706-849-4161 (PHONE)
762-585-9793 (FAX)

Hepatitis C Referral Form

Patient Demographics:

First Name:	Last Name:	Date of Birth: M ☐ F ☐
Address:	City:	State: Zip:
Phone:	Social Security #:	Allergies:

Diagnosis and Clinical Information: **(Attach clinical information, lab work, current medication list, and medication history)**

Requested HCV Treatment Start Date:_____ **HCV Genotype**: 1A☐ 1B☐ 2☐ 3☐ 4☐ 5☐ 6☐ **Diagnosis Code(s)** (ICD-10):_____ **Diagnosis Date**:_____ **Starting RNA Titer**:_____ **Cirrhosis present**?: ☐ Yes ☐ No **FibroSURE score**:_____ **Treatment Status**: Naive☐ Partial Response☐ Null Response☐ Non-Responsive☐ Relapse☐ **HIV co-infected?** ☐ Yes ☐ No	**Is Patient Currently on HCV Treatment?**: ☐ Yes ☐ No **If yes, last Treatment Date**:_____ **Prior Treatments**:_____ **Reason for Discontinuation**:_____ **Has patient previously failed treatment that included a protease inhibitor?:** ☐ Yes ☐ No **Does patient have autoimmune hepatitis or another condition exacerbated by interferon or ribavarin?**: Yes☐ No☐	**Delivery Options:** ☐ First fill to office, refills to patient ☐ All fills to office ☐ All fills to patient

Prescription Information:

Drug	Strength	Directions	Quantity	Refills
Daklinza	☐ 30mg ☐ 60mg ☐ 90mg	☐ Take one tablet by mouth once daily with Sovaldi		
Epclusa	☐ 400mg/100mg	☐ Take one tablet by mouth once daily		
Mavyret	☐ 100mg/40mg	☐ Take 3 tablets by mouth once daily with food		
Ribavirin	☐ 200mg capsules ☐ 200mg tablets	☐ Take_____(tabs/caps) by mouth every morning and _____(tabs/caps) by mouth every night		
Sovaldi	☐ 400mg	☐ Take one tablet by mouth once daily		
Viekira Pak	☐ 12.5mg/75mg/50mg/ 250mg	☐ Take two tablets by mouth (12.5mg/75mg/50mg) once daily in the morning and take one tablet (250mg) twice daily (morning and evening) with a meal		
Viekira XR	☐ 200mg/8.33mg/50mg/ 33.33mg	☐ Take three tablets once daily with meals		
Vosevi	☐ 400mg/100mg/100mg	☐ Take one tablet by mouth once daily with food		
Zepatier	☐ 50mg/100mg	☐ Take one tablet by mouth once daily		
Other:				

Prescriber Information:

Name:		NPI:	DEA:
Address:		City:	State: Ga Zip:
Phone:	Fax:	Specialty:	Office Contact:

Updated April 2020

Prescriber Signature:_____**Date:**_____

By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy to serve as your designated prior authorization agent in dealing with third party payors and information contained in this form will be used for that purpose.