SYNERGEN Rx Specialty Pharmacy

HEPATITIS REFERRAL FORM

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NPI: 1811550528
synergenrx.com

PATIENT INFORMATION (please attach insurance card)

Name: ☐ M ☐ F DoB:

Street: City: State: Zip:

Phone: Phone: Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **B18.1** chronic viral hepatitis B
- ☐ **B18.2** chronic viral hepatitis C
- ☐ Other: _____

Treatment History

- ☐ Naïve
- ☐ Experienced
- ☐ Currently on therapy
  date started: _____

Clinical History

Viral Information
(please send copies of the most recent results)

HCV genotype:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

- ☐ HBV/HCV viral load
- ☐ HBsAg

Additional Labs
(please send copies of the most recent results)

- ☐ complete metabolic panel (CMP)
- ☐ complete blood count (CBC)
- ☐ coagulation (PT/INR)

Liver Status ☐ no cirrhosis ☐ compensated cirrhosis ☐ decompensated cirrhosis

Diagnostic test: ☐ FibroSure ☐ FibroTest ☐ FibroScan ☐ biopsy ☐ APRI
(please send copy of results)

Treatment History

Current medication(s) with date(s) started: _____

Prior medication(s) with dates of use: _____

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
Hepatitis B				
☐ entecavir (Baraclude)	☐ 0.5mg ☐ 1mg	Take 1 tablet by mouth once daily	30	
☐ tenofovir DF (Viread)	☐ 150mg ☐ 300mg	_____ mg by mouth every _____ hours		
☐ Vemlidy	☐ 25mg	Take 1 tablet by mouth once daily	30	
Hepatitis C				
☐ Epclusa	400/100mg	Take 1 tablet by mouth once daily for ☐ 12 ☐ 24 wks	28	
☐ Harvoni	400/90mg	Take 1 tablet by mouth once daily for ☐ 8 ☐ 12 ☐ 24 wks	28	
☐ Mavyret	100/40mg	Take 3 tablets PO once daily with food for ☐ 8 ☐ 12 ☐ 16 wks	84	
☐ Vosevi	400/100/100mg	Take 1 tablet by mouth once daily with food for 12 weeks	28	2
☐ ribavirin	200mg	☐ < 75kg: 600mg PO every morning & 400mg every evening ☐ ≥ 75kg: 600mg by mouth twice daily		
Other:				

PRESCRIBER INFORMATION

Prescriber: Supervising Physician:

Contact Name: Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: Ext: Fax:

Street: City: State: Zip:

Signature: Date: NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.