



HEPATITIS REFERRAL FORM

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 synergenrx.com

PATIENT INFORMATION (please attach insurance card)

Name:		<input type="checkbox"/> M	<input type="checkbox"/> F	DoB:	
Street:		City:		State:	Zip:
Phone:	Phone:	Allergies:			

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code <input type="checkbox"/> B18.1 chronic viral hepatitis B <input type="checkbox"/> B18.2 chronic viral hepatitis C <input type="checkbox"/> Other: _____	Clinical History	
	Viral Information <i>(please send copies of the most recent results)</i> HCV genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> HBV/HCV viral load <input type="checkbox"/> HBsAg	Additional Labs <i>(please send copies of the most recent results)</i> <input type="checkbox"/> complete metabolic panel (CMP) <input type="checkbox"/> complete blood count (CBC) <input type="checkbox"/> coagulation (PT/INR)
Treatment History <input type="checkbox"/> Naïve <input type="checkbox"/> Experienced <input type="checkbox"/> Currently on therapy date started: _____	Liver Status <input type="checkbox"/> no cirrhosis <input type="checkbox"/> compensated cirrhosis <input type="checkbox"/> decompensated cirrhosis Diagnostic test: <input type="checkbox"/> FibroSure <input type="checkbox"/> FibroTest <input type="checkbox"/> FibroScan <input type="checkbox"/> biopsy <input type="checkbox"/> APRI <i>(please send copy of results)</i>	

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				
<input type="checkbox"/> entecavir (Baraclude)	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg	Take 1 tablet by mouth once daily	30	
<input type="checkbox"/> tenofovir DF (Viread)	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg	_____ mg by mouth every _____ hours		
<input type="checkbox"/> Vemlidy	<input type="checkbox"/> 25mg	Take 1 tablet by mouth once daily	30	
Hepatitis C				
<input type="checkbox"/> Epclusa	400/100mg	Take 1 tablet by mouth once daily for <input type="checkbox"/> 12 <input type="checkbox"/> 24 wks	28	
<input type="checkbox"/> Harvoni	400/90mg	Take 1 tablet by mouth once daily for <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24 wks	28	
<input type="checkbox"/> Mavyret	100/40mg	Take 3 tablets PO once daily with food for <input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16 wks	84	
<input type="checkbox"/> Vosevi	400/100/100mg	Take 1 tablet by mouth once daily with food for 12 weeks	28	2
<input type="checkbox"/> ribavirin	200mg	<input type="checkbox"/> < 75kg: 600mg PO every morning & 400mg every evening <input type="checkbox"/> ≥ 75kg: 600mg by mouth twice daily		
Other:				

PRESCRIBER INFORMATION

Prescriber:		Supervising Physician:			
Contact Name:		Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> 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.