To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: ______________________________

Email: ______________________________

Direct Phone Line: ______________________________

Cell (optional, but preferred): ______________________________

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Hepatitis C Enrollment Form

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: / /	SS#: _____-_____-__________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: __________	Wt.: Ht.:

PRESCRIPTION

☐ **New** ☐ **Refill** | **Ship by:** ____/____/________ | **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** ________________________

Drug	Strength	Directions & Quantity	Refills
Epclusa® *(sofosbuvir/velpatasvir)*	☐400/100 mg Tablet	☐Take one tablet PO QD with or without food (Quantity: 28)	
Harvoni® *(ledipasvir/sofosbuvir)*	☐90/400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
Mavyret™	☐100/40 mg Tablet	☐ Take three tablets PO QD with food (Quantity: 84)	
Sovaldi®	☐400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
Viekira Pak®	☐12.5/75/50 mg Tablet	☐ Take two pink tablets PO QD (morning) and one beige tablet PO BID (morning and evening) with a meal (Quantity: 56/56)	
Vosevi®	☐400/100/100 mg Tablet	☐Take one tablet PO QD with food (Quantity: 28)	
Zepatier®	☐50/100 mg Tablet	☐Take one tablet PO QD with or without food (Quantity: 28)	

RIBAVIRIN PRODUCTS

Directions & Quantity			
☐ Take____mg QAM, ____mg QPM (Quantity: ____)	☐ **Ribavirin Tablet**	☐ **Ribavirin Capsule**	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK REGARDING THERAPY*****

Diagnosis: ☐ B18.2 Chronic Hepatitis C Virus (HCV) | Date of Diagnosis:____/____/________ | **Treatment Naïve?** ☐ Yes ☐ No

Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Subtype:** ☐ A ☐ B ☐ A/B ☐ N/A | **Baseline viral load:** ____________**IU/mL Date:** ____/____/________

Cirrhosis: ☐ Yes ☐ No (if yes, is it: ☐ compensated ☐ decompensated) | **Co-infection status:** ☐ HIV ☐ HBV ☐ N/A

Degree of liver fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 | **Polymorphism(s):** ☐ NS5A ☐ IL28B ☐ Q80K ☐ N/A

Prior HCV Treatment:	Date(s) of treatment:	Treatment weeks:	Treatment Response:
________________	________________	__________	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed
________________	________________	__________	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed
________________	________________	__________	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed

Allergies: ________________________________ | **Expected Duration of Therapy:** ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and copay assistance foundations.

PRODUCT SUBSTITUTION PERMITTED	**DISPENSE AS WRITTEN**
X ____________________ Date: ____/____/________	**X** ____________________ Date: ____/____/________

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.