CEDRA

HEPATITIS C
REFERRAL FORM

FAX: 888.889.7129
TOLL FREE: 844.233.7279
CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:

SSN#: Language: ☐ English ☐ Other

Address: Sex: ☐ Male ☐ Female Height: Weight: ☐ lbs ☐ kg

City: State: Zip: Known Allergies:

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:

Address: Phone: E-mail:

City: State: Zip: Key Contact: Phone: Fax:

STATUS UPDATE PREFERENCE: ☐ Phone ☐ Text ☐ Fax ☐ E-mail:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis/ICD-10 Code: ☐ B18.2 ☐ Other: Genotype: Viral Load: NS5A80K: ☐ GFR

Response Status: ☐ Naive ☐ Null ☐ Partial Prior Treatment Regimen, Date, Reason for DC:

Cirrhosis: ☐ Yes ☐ No (☐ Compensated ☐ Decompensated) Fibrosis Score: Reason for RBV Ineligibility:

Comorbidities: ☐ HIV ☐ HBV ☐ Diabetes ☐ CKD ☐ ESRD ☐ Other:

PRESCRIPTION INFORMATION

☐ EPCLUSA®

☐ 400 mg/100 mg

Take 1 tablet by mouth daily with or without food.

PATIENT POPULATION	TREATMENT	DURATION
GT1-6: w/o Cirrhosis and compensated Cirrhosis (Child-Pugh A)	EPCLUSA	12 weeks
GT1-6: with decompensated Cirrhosis (Child-Pugh B or C)	EPCLUSA + RBV	12 weeks

QTY: 28-day supply

☐ HARVONI®

☐ 90 mg/400 mg

Take 1 tablet by mouth daily with or without food.

DURATION OF THERAPY GUIDANCE FOR CHC GT1	DURATION	REFILLS
Naive Non-Cirrhotic HCV RNA >6 million IU	12 weeks	2
Naive Non-Cirrhotic HCV RNA <6 million IU	8 weeks	1
Naive Non-Cirrhotic and Cirrhotic	12 weeks	2
Non-Responder Non-Cirrhotic	12 weeks	2
Non-Responder Cirrhotic	24 weeks	5

QTY: 28-day supply

☐ MAVYRET™

☐ 100 mg/40 mg

Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food.

GENOTYPE	Previously Treated with a Regimen Containing:	No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5 or 6	Treatment-Naive Patients	8 weeks	12 weeks
1	Ledipasvir and Sofosbuvir or Daclatasvir with PEG-INF and Ribavirin	16 weeks	16 weeks
1	Simeprevir and Sofosbuvir, or Simeprevir, Boceprevir, or Telaprevir with PEG-INF and Ribavirin	12 weeks	12 weeks
1, 2, 4, 5 or 6	Prior treatment experience with regimens containing INF, PEG-INF, Ribavirin, and/or Sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	8 weeks	12 weeks
3		16 weeks	16 weeks

QTY: 28-day supply

☐ RIBAVIRIN®

☐ 200 mg

QTY: 28-day supply

☐ VIEKIRA PAK®
☐ VIEKIRA XR™

☐ 12.5/75/50/250 mg
☐ 200/8.33/50/33.33 mg

☐ VIEKIRA PAK® Take as directed with a meal. ☐ VIEKIRA XR™ 3 tablets taken by mouth once daily with a meal.
(Follow GT1 dosing in patients with unknown GT1 subtype or mixed GT. Viekira Pak w/ RBV for 12 weeks may be considered based upon prior treatment history.)

PATIENT POPULATION	TREATMENT	DURATION	REFILLS
GT1a w/o Cirrhosis	Viekira Pak w/ RBV	12 weeks	2
GT1a w/ Cirrhosis	Viekira Pak w/ RBV	24 weeks	5
GT1b w/ and w/o Cirrhosis	Viekira Pak	12 weeks	2

QTY: 28-day supply

☐ VOSEVI™

☐ 400/100/100 mg

Take 1 tablet by mouth once daily with food.

GENOTYPE	PATIENTS PREVIOUSLY TREATED WITH AN HCV REGIMEN CONTAINING:	DURATION
1, 2, 3, 4, 5, or 6	An NS5A inhibitor	12 weeks
1a or 3	Sofosbuvir without an NS5A inhibitor	12 weeks

QTY: 28-day supply

☐ ZEPATIER™

☐ 50 mg/100 mg

Take 1 tablet by mouth daily with or without food if taken without RBV.

PATIENT POPULATION	TREATMENT	DURATION
GT1a: Treatment-naive or PegIFN/RBV- experienced without baseline NS5A polymorphisms	ZEPATIER	12 weeks
GT1a: Treatment-naive or PegIFN/RBV- experienced with baseline NS5A polymorphisms	ZEPATIER + RBV	16 weeks
GT1b: Treatment-naive or PegIFN/RBV- experienced	ZEPATIER	12 weeks
GT1a or 1b: PegIFN/RBV/PI-experienced	ZEPATIER + RBV	12 weeks
GT4: Treatment-naive	ZEPATIER	12 weeks
GT4: PegIFN/RBV-experienced	ZEPATIER + RBV	16 weeks

QTY: 28-day supply

☐

Deliver To: ☐ Patient Home ☐ MD Office

Prescriber Signature: (Please sign and date below.)
Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

SUBMIT FORM CLEAR FORM