HEPATITIS C REFERRAL FORM

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Thousand Oaks, CA 91361
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Beneva SPECIALTY PHARMACY

Ship to: ☐ Patient ☐ Prescriber ☐ Other _____

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Allergies: _____ ☐ NKDA
Phone: _____ Alternate Phone: _____
Email: _____ Preferred Contact: ☐ Phone ☐ Email
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax a copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Diagnosis: _____
☐ B18.2 Chronic Viral Hepatitis C ☐ Other ICD-10: _____

Genotype: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other: _____ | Viral Load: _____ RNA Test Date: _____

☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis | Fibrosis Score: _____

HIV Co-infected: ☐ Yes ☐ No | Weight: _____lb/kg | Height: _____in/cm

Is patient: ☐ Naive ☐ Partial Responder ☐ Non-Responder ☐ Relapser; Last Therapy Date: _____ Product: _____

Is patient currently on HCV therapy? ☐ Yes ☐ No Therapy Start Date: _____ Product: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
Duration of Therapy: ☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks ☐ 24 Weeks				
☐ **Epclusa**	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take 1 tablet by mouth once daily	28 days	_____
☐ **Harvoni**	Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir	Take 1 tablet by mouth daily with or without food. Do not take within 4 hours of antacids	28 days	_____
☐ **Mavyret**	Fixed-dose combination tablet of 100 mg glecaprevir / 40 mg pibrentasvir	Take 3 tablets by mouth once daily with food	28 days	_____
☐ **Vosevi**	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir / 100 mg voxilaprevir	Take 1 tablet by mouth once daily with food	28 days	_____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"Dispense as Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May No Substitute

Prescriber's Signature: _____
Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____
Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Beneva Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.

Updated 08/12/2026