HEPATITIS C REFERRAL FORM

BORO HALL Rx PHARMACY
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TEL: 732-968-0414 | FAX: 732-424-1988

FREE DELIVERY & SHIPPING TO HOME OR DOCTORS OFFICE

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last Updated: July 2017

Patient Name _____ SS# _____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Evening Tel _____ Cell _____ Email _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

ICD-10 Code ☐ B18.2 HCV (Chronic) HCV RNA Viral Load* _____ Date _____ Pretreatment (Viral Load) _____ Current Treatment (Viral Load) _____
Is Patient treatment naïve? ☐ Yes (naïve) ☐ No If No, what drugs _____ # of Weeks _____
Interferon ineligible? ☐ Yes ☐ No ☐ relapsed ☐ partial response ☐ null response
Is patient co-infected with HIV? ☐ Yes ☐ No Genotype* ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 6 Fibrosis Score/Test (stage)* _____
Does Patient have Cirrhosis? ☐ Yes ☐ No Drug and Alcohol Screening ☐ Yes ☐ No *If no, patient must obtain test*

Please forward all pertinent lab results for prior authorization

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **MAVYRET** 100 mg glecaprevir/40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets PO once daily with food QTY:_____ Refill x _____
Total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg
☐ Other:_____ QTY:_____ Refill x _____

☐ **VOSEVI** 400 mg sofosbuvir/100 mg velpatasvir/100 mg voxilaprevir tablet
SIG: ☐ Take 1 tablet PO daily with food for 12 weeks QTY:_____ Refill x _____
☐ Other:_____ QTY:_____ Refill x _____

ZEPATIER ☐ Grazoprevir 100mg/ Elbasvir 50mg tab GT 1 & 4 ONLY
NS5A test for GT1a patients ☐ Yes ☐ No ☐ ☐ 16 wks
SIG: Take one tablet PO daily QTY: 28 Refill x ____
with RIBAVIRIN? ☐ Yes ☐ No: See RIBAVIRIN box for dosages

☐ **VIEKIRA XR** QTY:_____ Refill x _____
Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO with meal for:
☐ 12 weeks w/ Ribavirin (GT 1a, w/o cirrhosis)
☐ 24 weeks w/ Ribavirin (GT1a, w/ compensated cirrhosis)
☐ 12 weeks (GT 1b, w/ or w/o compensated cirrhosis)

☐ **VIEKIRA PAK** QTY 28 Day Supply Refill x _____
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige)
Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food

EPCLUSA Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tab 1x day for 12 wks QTY:___ Refill x ____
☐ 1 tab 1x day for 12 wks WITH ribavirin QTY:___ Refill x ____

DAKLINZA GT 1 & 3 ONLY
☐ 30 mg with 400 mg SOVALDI QTY:28 Refill x ____
☐ 60 mg with 400 mg SOVALDI QTY:28 Refill x ____
SIG: take 1 tablet each daily

☐ **TECHNIVIE** QTY____ Refill x____ GT4 ONLY
Paritaprevir/Ritonavir (75/50mg) and Ombitasvir (12.5mg)
SIG: two tablets QAM with meal and with RIBAVIRIN

☐ **RIBAVIRIN** ☐ **RIBAPAK** ☐ **MODERIBA**
Dosing ☐ 600mg/day 200mg QAM 400mg QPM
☐ 800mg/day 400mg QAM 400mg QPM
☐ 1000mg/day 600mg QAM 400mg QPM
☐ 1200mg/day 600mg QAM 600mg QPM
☐ 200mg SIG: _____
☐ Other:_____
QTY 28 days Refill x ____

☐ **HARVONI** Ledipasvir 90 mg / Sofosbuvir 400 mg
SIG: Take 1 tablet by mouth daily QTY:28 Refill x ____

OLYSIO (Simeprevir) ☐ 150mg capsule QTY ____ Refill x ____
SIG: _____

SOVALDI (Sofosbuvir) 400mg tablet QTY _____ Refill x ____
Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks with Ribavirin (Genotype 2)
☐ 24 weeks with Ribavirin (Genotype 3)
Other Combination: _____

☐ **PEG INTRON REDIPEN** ☐ **PEGASYS**
SIG: _____
Strength: _____ QTY: 28 days Refill x _____

SUPPORTIVE THERAPIES Strength _____ QTY _____ Refill x _____
☐ Procrit ☐ Epogen ☐ Neulasta ☐ Aranesp ☐ Neupogen
SIG: _____

HEPATITIS B ORAL THERAPIES
☐ Baraclude ☐ 0.5mg ☐ 1.0mg ☐ Epivir HBV 100mg
☐ Hepsara 10mg ☐ Tyzeka 600mg
Additional Directions: _____
☐ 1 Tablet po QD Quantity: ☐ 1 Month ☐ 3 Month

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____