HEPATITIS C REFERRAL FORM

159 East Gun Hill Road, Bronx, NY 10467
Phone: 347.913.4656 Fax: 718.231.2727

Today's Date ______________

☐ NEW PATIENT ☐ CURRENT PATIENT

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

Previously treated ☐ No ☐ Yes, what drugs ______ Interferon ☐ Yes ☐ No # of Weeks ______ ☐ relapsed ☐ partial response ☐ null response
ICD-10 Code ☐ B18.2 HCV (Chronic) Genotype ______ Subtype ______ Liver Biospsy ☐ Yes ☐ No Date ______ Results ______
Other Lab Results ALT ______ Date ______ AST ______ Date ______ Hgb ______ Date ______ HCV RNA ______ Date ______

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

ZEPATIER
☐ Grazoprevir 100mg/ Elbasvir 50mg tab GT 1 & 4 ONLY
NS5A test for GT1a patients ☐ Yes ☐ No ☐ 12 wks ☐ 16 wks
SIG: Take one tablet by mouth daily QTY: 28 Refill:______
with RIBAVIRIN? ☐ Yes ☐ No: See RIBAVIRIN box for dosages

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

☐ VIEKIRA PAK
QTY 28 Day Supply Refills ______
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

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

EPCLUSA
Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tablet once a day for 12 weeks QTY:____ Refill x___
☐ 1 tab 1x day for 12 weeks WITH ribavirin QTY:____ Refill x___

☐ TECHNIVIE
Genotype 4 ONLY
Paritaprevir/Ritonavir (75/50mg) and Ombitasvir (12.5mg)
SIG: two tablets QAM with meal and with RIBAVIRIN
QTY_____ Refill:_____

☐ 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 _____

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

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
Strength: ______
SIG: ______
Quantity: 28 days Refill ______

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

☐ VIEKIRA XR
SIG: Take 3 tablets PC with meal for 12/24 weeks

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, 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.

© Copyright 2016 - 2017 • Lemed Pharmacy