MORRISTOWN PHARMACY

HEPATITIS C REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel : 973 - 998 - 0287 | Fax : 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Last Updated: May 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 ☐ Bergen Ave Drugs - Specialty 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

EPCLUSA Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take1 tablet once a day for 12 weeks QTY:____ Refill x ____
☐ 1 tab 1x day for 12 weeks WITH ribavirin QTY:____ Refill x ____

ZEPATIER ☐ Grazoprevir 100mg/ Elbasvir 50mg tab GT 1 & 4 ONLY
NS5A test for GT1a patients ☐ Yes ☐ ☐ ☐ 16 wks
SIG: Take one tablet by mouth 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

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 _____

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

☐ 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 _____

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** _____

Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288** Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.