BERGEN AVE DRUGS
Specialty Pharmacy

HEPATITIS C REFERRAL FORM

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Tel 201.521.0545 | Fax 201.521.0546

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** ____

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