HEPATITIS C REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ Date of Birth _____
☐ Male ☐ Female SS# _____ Language _____
Address _____ Apt # _____
City _____ State _____ ZIP _____
Phone _____ Cell _____ Email _____
Allergies _____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

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

ICD-10 Code: ☐ B18.2 HCV (Chronic) ☐ Other _____ Previously treated ☐ No ☐ Yes, what drugs _____
Compensated Cirrohsis? ☐ Yes ☐ No HIV co-infected? ☐ Yes ☐ No
Interferon ☐ No, patient is naïve ☐ Yes If yes, ☐ relapsed ☐ partial response ☐ null response # of Weeks Interferon _____
HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **MAVYRET** 100 mg glecaprevir / 40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets by mouth daily with food QTY: 84 Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

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

DAKLINZA *GT3 ONLY*
☐ 30 mg / ☐ 400 mg SOVALDI QTY:28 Refill: _____
☐ 60 mg / ☐ 400 mg SOVALDI QTY:28 Refill: _____
SIG: take 1 tablet each dailly Total daily dose: _____

☐ **EPCLUSA** Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tablet by mouth daily for 12 weeks
☐ Take 1 tablet by mouth daily for 12 weeks WITH Ribavirin
QTY: _____ Refill: _____

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

☐ **OLYSIO** 150mg capsule QTY: _____ Refill: _____
SIG: Take 1 capsule by mouth daily for 12 weeks w/peginterferon & ribavirin

☐ **SOVALDI** 400mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **ZEPATIER** Grazoprevir 100mg/ Elbasvir 50mg tablet
SIG: Take one tablet by mouth daily QTY: 28 Refill: _____

PEGASYS QTY: ☐ 1 month ☐ 3 months Refill: _____
☐ **ProClick** 180mcg Autoinjector *(NDC 004-0365-30)* Inject SQ weekly
☐ **Pre-Filled Syringe** 180mcg/0.5ml *(NDC 004-0357-30)* Inject SQ weekly
☐ Other _____

PEG INTRON ☐ REDIPEN ☐ VIAL
☐ 50mcg/0.5ml ☐ 120mcg/0.5ml ☐ 80mcg/0.5ml ☐ 150mcg/0.5ml
SIG: _____
QTY: ☐ 1 month ☐ 3 months Refill: _____

☐ **RIBAVIRIN** ☐ **MODERIBA** ☐ **RIBAPAK**
☐ 600mg PO Daily; 200mg QAM, 400mg QPM
☐ 800mg PO Daily; 400mg QAM, 400mg QPM
☐ 1000mg PO Daily; 600mg QAM, 400mg QPM
☐ 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ Other 200mg Sig _____
QTY: _____ Refill: _____

☐ **TECHNIVIE** paritaprevir/ritonavir (75/50 mg) and ombitasvir (12.5 mg)
SIG: two tablets QAM with meal and with ☐ RIBAVIRIN
QTY: _____ Refill: _____ *GT4 ONLY*

☐ **VIEKIRA XR** Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO QAM 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)
QTY: _____ Refill: _____

☐ **VIEKIRA PAK** 12.5/75/50/250
SIG: Take 2 pink tabs (Ombitasvir/Paritaprevir/Ritonavir) PO once daily (AM) with food and one beige tab (Dasabuvir) PO twice daily (AM and PM) with food QTY: 112 tablets Refill: _____

☐ **EPOGEN VIAL** ☐ **PROCRIT VIAL**
SIG: _____ QTY: _____ Refill: _____

☐ **OTHER** _____
SIG: _____ QTY: _____ Refill: _____

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

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

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed form to **JERSEY SHORE PHARMACY** at **609.660.0101**

Visit us at **WWW.JERSEYSHORE.PHARMACY** for online fillable forms.