STAR CARE PHARMACY

"The First Wealth is Health"

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HEPATITIS C REFERRAL FORM

Date: _____ Attn: _____

Ship to ❒ Patient ❒ Physician ❒ Office Nurse/Training

Patient Name _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Home Tel _____ Work Tel _____
Cell _____ Email _____
Date of Birth _____ SS# _____
☐ Male ☐ Female Weight _____ Height _____

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

Insurance Information *(Complete or attach copies of cards)*

Primary Insurance: _____
ID#: _____
Group #: _____

Insured's Name: _____
City: _____ State: _____ Phone: ( ) _____ - _____
Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: ☐ B18.2 Hepatitis C (chronic) ☐ B18.1 Hepatitis B (chronic) ☐ Other _____
CD4 / T-Cell Count _____ Hgb / Hct _____ METAVIR Score _____
WBC _____ Weight _____ HCV Genotype _____ ALT _____ HCV RNA _____IU/ml
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

Prescription

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

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

DAKLINZA ☐ 30 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: _____
☐ 60 mg / ☐ 400 mg SOVALDI Qty: 28 Refills: _____
SIG: take 1 tablet each daily Total daily dose: _____ GT3 ONLY

☐ **VIEKIRA** Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) & Dasabuvir 250 mg tab (beige)
SIG: Take 2 pink tablets PO once daily (AM) with food and one beige tablet PO twice daily (AM and PM) with food. QTY 28 day supply Refills: _____

PEGASYS
☐ ProClick 135mcg Autoinjector (NDC 004-0365-30) Inject SQ wkly
☐ ProClick 180mcg Autoinjector (NDC 004-0365-30) Inject SQ wkly
☐ PFS 180mcg/0.5ml (NDC 004-0357-30) Inject SQ wkly
☐ Other _____
QTY: ☐ 1 month ☐ 3 month Refills: _____

PEG INTRON ☐ REDIPEN ☐ VIAL

Weight (lbs)	Strength (Dose)	Amount to Inject	Volume to inject
☐ < 88	50 mcg per 0.5 mL	50 mcg	0.5 mL
☐ 88 – 111	80 mcg per 0.5 mL	64 mcg	0.4 mL
☐ 112 – 133		80 mcg	0.5 mL
☐ 134 – 144	120 mcg per 0.5 mL	96 mcg	0.4 mL
☐ 145 – 166		96 mcg	0.4 mL
☐ 167 – 177		120 mcg	0.5 mL
☐ 178 – 187			
☐ 188 – 231	150 mcg per 0.5 mL	150 mcg	0.5 mL
☐ >231	***	***	***

QTY: ☐ 1 month ☐ 3 months Refill _____
***Dose of 1.5 mcg/kg/week should be calculated based on patient weight. Two vials of PegIntron may be necessary to provide the dose.

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

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

☐ **RIBAPAK** | ☐ **MODARIBA** | ☐ **RIBASPHERE** | ☐ **RIBAVIRIN®**
☐ 600mg PO Daily; 200mg QAM, 400mg QPM
☐ 800mg PO Daily; 400mg QAM, 400mg QPM
☐ 1000mg PO Daily; 400mg QAM, 600mg QPM
☐ 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ 200mg SIG _____
Qty: _____ Refills: _____

☐ **SOVALDI** 400mg tablet Qty: _____ Refills: _____
SIG: 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)

☐ **OLYSIO** 150mg capsule Qty: _____ Refills: _____
SIG: Take 1 capsule by mouth daily for 12 weeks with Peginterferon and Ribavirin

INFERGEN ___ mcg ☐ REDIPEN ☐ VIAL
Includes 25G 1/2" syringes and alcohol pads with all dispenses
Qty: _____ Refills: _____

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