

FAX: 888-865-8954

PHARMACY

↓ Must Be Filled Out ↓

New Patient  Current

Patient's Name \_\_\_\_\_  
 D.O.B. \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 E-mail Address \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Does patient have a secondary insurance?  Yes  No

Date \_\_\_\_\_  
 Date Medication Needed: \_\_\_\_\_  
 Prescriber's Name and Title \_\_\_\_\_  
 Street Address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_  
 DEA # \_\_\_\_\_  
 Allergies: \_\_\_\_\_

In order to dispense brand, BRAND MEDICALLY NECESSARY must be *handwritten* here:

Diagnosis/Clinical Information

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ Genotype: \_\_\_\_\_ Subtype: \_\_\_\_\_ Viral Load: \_\_\_\_\_  
 NS Q80K Polymorphism Results: \_\_\_\_\_ Prior Treatment and Date: \_\_\_\_\_  
 Response Status:  Naive  Null  Partial  Relapse Compensated Cirrhosis: Yes No F-Score: \_\_\_\_\_

Prescription Information

Medication	Dose/Strength	Sig	Qty	Refills
<input type="checkbox"/> Daklinza® (Daclatasvir)	<input type="checkbox"/> 60mg <input type="checkbox"/> 30mg	Take 1 tablet by mouth daily with or without food in combination with sofosbuvir.	28 day supply	
<input type="checkbox"/> Harvoni® (Ledipasvir/Sofosbuvir)	<input type="checkbox"/> 90mg/400mg	Take 1 tablet by mouth daily with or without food.	28 day supply	
<input type="checkbox"/> Moderiba® <input type="checkbox"/> Ribapak®	<input type="checkbox"/> 600mg <input type="checkbox"/> 800mg <input type="checkbox"/> 1000mg <input type="checkbox"/> 1200mg	<input type="checkbox"/> 200mg Every Morning, 400mg Every Evening <input type="checkbox"/> 400mg Every Morning, 400mg Every Evening <input type="checkbox"/> 600mg Every Morning, 400mg Every Evening <input type="checkbox"/> 600mg Every Morning, 600mg Every Evening	28 day supply	
<input type="checkbox"/> Ribasphere® (Generic Ribavirin)	<input type="checkbox"/> 200mg			
<input type="checkbox"/> Simeprevir (Olysio)	<input type="checkbox"/> 150mg	Take 1 capsule by mouth daily with food. (Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi)	28 day supply	
<input type="checkbox"/> Sovaldi® (Sofosbuvir)	<input type="checkbox"/> 400mg	Take 1 tablet by mouth daily with or without food.	28 day supply	
<input type="checkbox"/> Technivie® (Ombitasvir, Paritaprevir, and Ritonavir tablets)	<input type="checkbox"/> 12.5mg/75mg/50mg	Take 2 ombitasvir, paritaprevir, ritonavir tablets by mouth once daily in the morning with a meal without regard to fat or calorie content (Technivie is FDA approved for use with ribavirin)	28 day supply	
<input type="checkbox"/> Viekira Pak® (Ombitasvir, Paritaprevir, and Ritonavir tablets copackaged with Dasabuvir tablets)	<input type="checkbox"/> 12.5mg/75mg/50mg/250mg	Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (morning and evening) with a meal without regard to fat or calorie content.	28 day supply	
<input type="checkbox"/> Zepatier (Elbasvir/Grazoprevir)	<input type="checkbox"/> 50mg/100mg	Take 1 tablet daily with or without food.		
<input type="checkbox"/> Other:				
<input type="checkbox"/> Other:				

Physician Office Contact: Name: \_\_\_\_\_ Email: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_