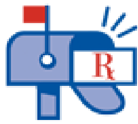

Mail-Meds CLINICAL PHARMACY

2692 Oak Ridge Court
Fort Myers, FL 33901
www.mailmeds.com

Patient Referral Form – HEPATITIS C

Submit Form: Toll-Free Phone: 800-939-2022
Toll-Free Fax: 855-523-0910
E Scribe: NCPDP: 1099919 NPI: 1558369140

PATIENT INFO

Last, First Name:
Phone #: Cell/Work #:
Home Address City State Zip
Shipping Address (if different from home address)
Social Security # Date of Birth / /
Height Weight o Male o Female

PRESCRIBER INFO

Today's Date
Prescriber
NPI # DEA #
Address City State Zip
Phone # Fax #
Office Contacts

INSURANCE

Primary Insurance:______
Policy #______ Group ______
Insurance Phone______

Secondary Insurance (if applicable)______
Policy #______ Group ______
Insurance Phone ______

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

CLINICAL INFORMATION (Please Attach Labs)

Diagnosis (ICD-9 code) □ 070.54 Chronic □ 070.7 Viral Hepatitis C □ Other ________ □ Other ________ □ Other ________ HIV Co- Infection: □ Yes □ No

HCV Genotype: □ 1a □ 1b □ 2a □ 2b □ 3a □ 3b □ 4 □ Other HCV/HBV Viral load:______Copies/ml ALT:______

Previously treated for HCV? □ Yes □ No If yes, is patient □ Partial Responder □ Relapser Last day of previous treatment: ______

Fibroscan: □ Yes □ No Fibrosure: □ Yes □ No

Liver Biopsy: □ Yes □ No Fibrosis Present? □Yes □ No Specify infection ineligibility (if applicable) ______

Deliver to: □ Patient's Shipping Address □ MD's office □ 1st dose to MD's office, remaining refills to Patient's Shipping Address

Dispensing options: □ Manufacturer's packaging/vials or □ Medbox™ Personalized Pill Box System

COMPLETE DRUG THERAPY INFORMATION IN SECTION BELOW *OR* ATTACH COMPLETED PRESCRIPTION

Class	Drug	Directions	Supply	Refills
NS5B INHIBITOR & PROTEASE INHIBTOR	□ Zepatier (Elbasvir-50mg Grazoprevir 100mg)	□ Take 1 tablet (50mg/100mg) once daily □ With Food □ Without Food	28 day supply	refills
NUCLEOTIDE NS5B INHIBITOR	□ Sovaldi™ Tablets (sofosbuvir)	□ Take 400mg (1 tablet) by mouth once per day. May be taken with or without food Genotype 1 or 4 — Sovaldi™ + Peg-Interferon Alfa + Ribavirin — 12 wks Genotype 2 — Sovaldi™ + Ribavirin — 12 wks Genotype 3 — Sovaldi™ + Ribavirin — 24 wks	28 day supply	refills
PROTEASE INHIBTOR	□ Olysio™ Capsules (simeprevir)	□ Take 150mg (1 capsule) by mouth once per day with food	28 day supply	refills
RIBAVIRIN	□ Riba-Pak® (ribavirin)	□ 600mg AM and 600mg PM (1200mg) □ 600mg AM and 400mg PM (1000mg) □ 400mg AM and 400mg PM (800mg) □ 400mg AM and 200mg PM (600mg) □ Other Dosage: _______mg AM and _______mg PM	28 day supply	refills
RIBAVIRIN	□ Ribavirin 200mg Tablet	□ Take _________mg AM and _________mg PM	28 day supply	refills
COMBO	□ Harvoni 90mg/400mg (90Ledipisvir/400Sofosbuvir)Tablet	□ Take 1 tablet (90mg/400mg) once daily	28 day supply	refills
COMBO	□ Viekira Pak 12.5- 75.5 250 tablets	□ Take 2 tablets (AV1) + 1 Tablet (AV2) in AM w/ food + Take 1 tablet (AV2) in PM GT 1a, without Cirrhosis — Viekira Pak + RBV — 12 wks GT 1a with Cirrhosis — Viekira Pak + RBV — 24 wks GT 1b without Cirrhosis — Viekira Pak — 12 wks GT 1b with Cirrhosis — Viekira Pak + RBV — 12 wks GT HCV/HIV-1 Co- infected: Follow dosing recommendation above	28 day supply	refills

OTHER MEDS:

______ D.A.W. ______ ______ ______

Prescriber's Signature — Office Contact Name (Nurse, MA, Other) — Preferred phone number & extension — Date