



HEPATOLOGY REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920

NPI# 1922103142 NABP# 0547185

info@aps-rx.net APS-rx.net



- Phone Order
- Home Work
- Ship to:
 Physician Office
 Nurse / Training
 APS Pharmacy

Patient Name _____ Date of Birth _____ Male Female
Address _____ Apt # _____ City _____ State _____ Zip _____
Telephone _____ Cell _____ SSN _____ Email _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____
Primary Insurance _____ ID# _____ Group # _____
Insured's Name _____ Employer _____
City _____ State _____ Phone _____

ICD-10 Code B18.2 HCV (Chronic) Other _____ relapsed partial response null response
Previously treated No Yes, what drugs _____ Interferon Yes No # of Weeks _____
(IU)Date of Labs _____ ALT _____ AST _____ Hgb _____
HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ eGFR _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MAVYRET™ 100mg glecaprevir / 40mg pibrentasvir tablet
SIG: Take 3 tablets orally once daily with food for:
 8 weeks (No Cirrhosis) or 12 weeks (Cirrhosis)
Total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg QTY 84 Refill _____

VOSEVI™ 400mg sofosbuvir/ 100mg velpatasvir/ 100mg voxilaprevir tablet
SIG: Take 1 tablet by mouth daily with food for 12 weeks QTY 28 Refill _____
 Other: _____ QTY _____ Refill _____

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

EPCLUSA® Sofosbuvir 400mg/ Velpatasvir 100mg tablet
SIG: Take 1 tablet by mouth daily QTY 28 Refill _____

SOVALDI® (SOFOSBUVIR) 400mg tablet QTY 28 Refill _____
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)
 Other: _____

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

DAKLINZA™ 30mg OR 60mg / 400mg SOVALDI GT3 ONLY
SIG: Take 1 tablet each daily QTY 28 Refill _____

VIEKIRA XR™ QTY 84 Refill _____
 Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
Directions: Take 3 tablets PO QAM with meal for 12 weeks 24 weeks

TRULANCE™ 3mg SIG: Take 1 tablet each daily QTY 30 Refill _____

VIEKIRA PAK® Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75mg/50mg tablets (pink) and Dasabuvir 250mg tablet (beige)
Directions: Take 2 pink tablets PO once daily (AM) with food and one beige tablet PO twice daily (AM and PM) with food. QTY 112 Refill _____

ENTYVIO® 300MG
SIG: Starter: Infuse 300mg IV at weeks 0, 2, and 6, then maintenance QTY 3 Refill _____
 Maintenance: Infuse 300mg IV every 8 weeks QTY 1 Refill _____

TECHNIVIE™ Paritaprevir/Ritonavir (75/50mg) and Ombitasvir (12.5mg) GT4 ONLY
SIG: two tablets QAM with meal with RIBAVIRIN QTY 1 week supply Refill _____

PEGASYS®
 ProClick 135mcg Autoinjector Inject SQ weekly
 ProClick 180mcg Autoinjector Inject SQ weekly
 Pre-Filled Syringe 180mcg/ 0.5ml Inject SQ weekly
 Other: _____
QTY: 1 month 3 month Refill _____

RIBAVIRIN® 200mg CAP 200mg TAB Patient Weight (kg) _____
SIG: _____ QTY _____ Refill _____

Weight (lbs)	Strength (Dose)	Amount to Inject	Volume to inject
<input type="checkbox"/> < 88	50 mcg per 0.5 mL	50 mcg	0.5 mL
<input type="checkbox"/> 88 - 111	80 mcg per 0.5 mL	64 mcg	0.4 mL
<input type="checkbox"/> 112 - 133		80 mcg	0.5 mL
<input type="checkbox"/> 134 - 144	120 mcg per 0.5 mL	96 mcg	0.4 mL
<input type="checkbox"/> 145 - 166		96 mcg	0.4 mL
<input type="checkbox"/> 167 - 177		120 mcg	0.5 mL
<input type="checkbox"/> 178 - 187			
<input type="checkbox"/> 188 - 231	150 mcg per 0.5 mL	150 mcg	0.5 mL
<input type="checkbox"/> >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.

OLYSIO® (SIMEPREVIR) 150mg capsule QTY 28 Refill _____
 Take 1 capsule by mouth daily for 12 wks w/peginterferon and ribavirin
 Take 1 capsule by mouth daily with Sovaldi

Include 25G 1/2" syringes and alcohol pads with all injectables
 NEUPOGEN® 300mcg PFS 480mcg PFS
 300mcg VIAL 480mcg VIAL
 PROCRT® 10,000IU 20,000IU 40,000IU

NEXAVAR® 200mg 2 TABS PO BID
 XIFAXAN® 200mg 550mg
 1 200mg TAB PO TID x 3 Days QTY 9 Refill _____
 1 550mg TAB PO BID QTY 60 Refill _____
 1 550mg Tab PO TID x 14 Days QTY 42 Refill _____
 RELISTOR® 8mg PFS 12mg PFS 150mg TABLET
SIG: _____ QTY _____ Refill _____

HEPATITIS B ORAL THERAPIES
 Baraclade® 0.5mg 1.0mg **Epivir® HBV** 100mg
 Hepsera® 10mg **Vemlidy®** 25mg **Viread®** 300mg
SIG: _____ QTY _____ Refill _____

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

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