ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

HEPATOLOGY REFERRAL FORM

Date Needed _____

☐ Phone Order

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

☐ 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 _____ Member ID _____
RxBIN _____ Rx PCN _____ Rx Grp _____
Member Services Number _____ Provider Services Number _____

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 _____

HARVONI® ☐ Ledipasvir 90mg / Sofosbuvir 400mg
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: _____

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

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

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 _____

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.

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 _____

EPCLUSA® ☐ Sofosbuvir 400mg/ Velpatasvir 100mg 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 _____

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

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 _____

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

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

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
☐ **PROCRIT®** ☐ 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
☐ **Baraclude®** ☐ 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**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.