ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

HEPATITIS C REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date | Anticipated Start Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name ____ SS#____ DOB ____ Height ____ Weight ____ ☐ Male ☐ Female
Street Address ____ Apt # ____ City ____ State ____ Zip ____
Evening Tel ____ Cell ____ ☐ Text Message Allowed Email ____
Caregiver Name ____ Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy
Allergies ____ Comorbidities ____
Current Medications (if necessary, please fax a complete list) ____

ICD-9 Code ☐ 070.54 HCV (Chronic) ☐ Other ____ Date ____ Results____
ALT ____ Date ____ AST ____ Date ____ Hgb ____ Date ____ HCV RNA ____ Date ____
Is patient co-infected with HIV? ☐ Yes ☐ No Genotype ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 6 Subtype ____ Fibrosis Score____

Does Patient have a history of recieving treatment? ☐ Yes ☐ No (naïve) If yes, indicate medication including dates & dosage: ____
If yes, please indicate accordingly: ☐ Non-Responder to previous treatment ☐ Partial Responder to previous treatment ☐ Relapser after Previous Treatment
☐ Continuation of Therapy | Date Started ____ Interferon ☐ Yes ☐ No # of Weeks ____ *Please forward all pertinent lab results*

Insured's Name____ Relation to Patient ____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ____
Prescription Card ☐ Yes ☐ No If Yes, Carrier ____ Tel ____ Fax ____ Policy/Group# ____
Bin# ____ Pcn#____ RXID# ____ RX Group# ____

Prescriber's Name ____ Office Contact ____
Street Address ____ Suite # ____ City____ State ____ Zip ____
Tel ____ Fax ____ Email ____
License# ____ NPI# ____ UPIN# ____ DEA# ____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ VIEKIRA PAK
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink)
Dasabuvir 250 mg tab (beige)

Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food

OLYSIO (Simeprevir)
☐ 150mg capsule QTY____ Refill x____
Take 1 capsule with food daily for 12 wks w/peginterferon and ribavirin

SOVALDI (Sofosbuvir)
400mg tablet QTY ____ Refills ____
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)

VICTRELIS
☐ 800mg (4 x 200mg) QTY 28 days (336 caps) Refill x____
Directions: 3x daily with food, start day 29 of peginterferon and ribavirin

PEG INTRON REDIPEN
☐ 50mg ☐ 80mg ☐ 120mg ☐ 150mg
Quantity: 28 days (4 pens) Refill x ____
Dose and Sig:____

PEGASYS
☐ **ProClick** 135mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ **ProClick** 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ **Pre-Filled Syringe** 180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly
☐ Other ____
Quantity: 28 days (4 syringes) Refill x ____

SUPPORTIVE THERAPIES
☐ Procrit ☐ Epogen
☐ Neulasta ☐ Aranesp ☐ Neupogen
Strength ____ Qty ____ Refill x ____
Directions ____

☐ RIBAPAK ☐ MODERIBA
Please write DAW in this box ☐

Dosing	QTY 28 days Refill x ____
☐ 600mg/day	200mg QAM 400mg QPM
☐ 800mg/day	400mg QAM 400mg QPM
☐ 1000mg/day	600mg QAM 400mg QPM
☐ 1200mg/day	600mg QAM 600mg QPM
☐ Other:____	____

HARVONI
☐ Ledipasvir 90mg / Sofosbuvir 400mg
Take 1 tablet by mouth daily 28 Day Supply Refills x ____

HEPATITIS B ORAL THERAPIES
☐ Baraclude ☐ 0.5mg ☐ 1.0mg ☐ Epivir HBV 100mg
☐ Hepsara 10mg ☐ Tyzeka 600mg
1 Tablet po QD Additional Directions: ____
Quantity ☐ 1 Month ☐ 3 Month

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

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