GASTRO HEALTH

Specialty Pharmacy

HEPATOLOGY

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DATE: ______________ NEEDS BY DATE: _____________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ____________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

❑ 070.54 Chronic Hepatitis C ❑ 572.2 Hepatic Encephalopathy ❑ 155.0 Hepatocellular Carcinoma ❑ Other: ____________

Genotype: ❑ 1 ❑ 1a (Q80K Polymorphism: ❑ Yes ❑ No) ❑ 1b ❑ 2 ❑ 2a ❑ 2b ❑ 3 ❑ 3a ❑ 3b ❑ 4 ❑ 4a ❑ 4b Viral Load:____________ IU/ml Viral Load Date :_________

❑ Treatment Naive ❑ Previously Treated: Prior treatment used: ____________ ❑ Non-Responder ❑ Responder/Relapser

Duration of previous therapy: From ____________ to ____________ Total of: ________ months HIV Coinfected: ❑ Yes ❑ No HBV Coinfected: ❑ Yes ❑ No

Compensated Liver Disease: ❑ Yes ❑ No Cirrhosis: ❑ Yes ❑ No Metavir Score: ______ Solid Organ Transplant recipient: ❑ Yes ❑ No Awaiting Liver Transplant?: ❑ Yes ❑ No

PRESCRIPTION INFORMATION		QUANTITY	REFILLS
❑ Harvoni® 90mg/400mg Tablet	❑ Take 1 tablet by mouth daily with or without food	28 day supply	________
❑ Sovaldi® 400mg Tablet	❑ Take 1 tablet by mouth once per day	28 day supply	________
❑ Viekira Pak®	❑ Take 2 tablets (ombitasvir/paritaprevir/ritonavir) once daily in the morning and 1 tablet (dasabuvir) twice daily in the morning and evening with a meal as directed by the Pak	28 day supply	________
❑ Moderiba 200mg Tablet ❑ Ribavirin 200mg Tablet ❑ Ribavirin 200mg Capsule	❑ 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: Take ________ mg AM and ____________ mg PM	28 day supply	________
❑ Riba-Pak® (ribavirin) ❑ Moderiba 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)	28 day supply	________
❑ Olysio® 150mg Capsule	❑ Take 1 capsule by mouth once per day with food	28 day supply	________
❑ Pegasys® ❑ PFS ❑ ProClick	Inject: ❑ 180mcg subcutaneously weekly ❑ 135mcg subcutaneously weekly ❑ 90mcg subcutaneously weekly	28 day supply	________

❑ Peg-Intron® Redipen

Less than 88lbs	Less than 40kg	50mcg/0.5 ml	❑ 50mcg (0.5 ml) subcutaneously weekly
89-111	40-50	80mcg/0.5 ml	❑ 64mcg (0.4 ml) subcutaneously weekly
112-133	51-60		❑ 80mcg (0.5 ml) subcutaneously weekly
134-166	61-75	120mcg/0.5 ml	❑ 96mcg (0.4 ml) subcutaneously weekly
167-187	76-85		❑ 120mcg (0.5 ml) subcutaneously weekly
greater than 187	greater than 85	150mcg/0.5 ml	❑ 150mcg (0.5 ml) subcutaneously weekly

Peg-Intron® Redipen: QUANTITY 28 day supply; REFILLS ________

		QUANTITY	REFILLS
❑ Procrit	Inject: ❑ 40,000 units subcutaneously every week ❑ other: ____________	28 day supply	________
❑ Neupogen SingleJect	Inject: ❑ 300mcg ❑ 480 mcg subcutaneously ❑ every week ❑ twice weekly ❑ three times weekly	28 day supply	________
❑ Xifaxan 550mg Tablet	❑ Take 1 tablet by mouth twice daily **indicate previously failed therapy (Lactulose) _______	30 day supply	________

By signing this form and utilizing our services, you are authorizing Gastro Health Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

______________________________ ____________

Prescriber's Signature (no stamps) If Brand required check ❑ DAW Date

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