Enexia Specialty

HEPATITIS C REFERRAL FORM

252B Port Richmond Ave, Staten Island, NY 10302
Tel: (718) 556-0942
Fax: (718) 360-9655

Patient Name _____ SS#_____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Evening Tel _____ Cell _____ 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-10 Code ☐ B18.2 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☐ 5☐ 6☐ Subtype ____ Fibrosis Score _____ NS5A polymorphisms testing? ☐ Yes ☐ No
Does Patient have a history of receiving treatment? ☐ Yes ☐ No (naive) 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*

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

PRESCRIPTION

Please attach copies of front and back of Patient's Prescription Insurance Cards, most recent labs and Prescription.

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

SOVALDI (Sofosbuvir) 400mg tablet Refills _____
Take 1 tablet by mouth daily for:
☐ 12 Weeks with Ribavirin and Peginterferon (Genotype 1 or 4)
☐ 12 Weeks with Ribavirin (Genotype 2) ☐ 24 Weeks with Ribavirin (Genotype 3)

VIEKIRA XR PAK 28 Day Supply Refills _____
☐ Dasabuvir/Ombitasvir/Paritaprevir/Ritonavir 200mg/8.33mg/50mg/33.33mg
Directions:Take 3 tabs once daily with food.

☐ **VIEKIRA PAK** 28 Day Supply Refills _____
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75mg/50mg tabs (Pink)
Dasabuvir 250mg tabs (Beige)
Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food.

☐ **RIBAVIRIN** ☐ **MODERIBA**
Please write DAW in this box ☐

Dosing	QTY 28 days	Refill ____
☐ 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: _____	_____	

ZEPATIER (elbasvir and grazoprevir) 50mg/100mg tablets

☐ **GT1a:**	Treatment-naive or PegIFN/RBV-experienced without baseline NS5A polymorphisms	ZEPATIER	12 wks
☐ **GT1a:**	Treatment-naive or PegIFN/RBV-experienced with baseline NS5A polymorphisms	ZEPATIER with RBV	16 wks
☐ **GT1b:**	Treatment-naive or PegIFN/RBV-experienced	ZEPATIER	12 wks
☐ **GT1a/GT1b:**	PegIFN/RBV/PI-experienced	ZEPATIER with RBV	12 wks
☐ **GT4:**	Treatment-naive	ZEPATIER	12 wks
☐ **GT4:**	PegIFN/RBV-experienced	ZEPATIER with RBV	16 wks

Quantity: 28 days Refill _____

☐ **EPCLUSA** (Sofosbuvir 400mg / Velpatasvir 100mg))
Take 1 tablet by mouth daily 28 Day Supply Refills _____
☐ 12 Weeks without Cirrhosis ☐ 12 Weeks with Cirrhosis + Ribavirin
EPCLUSA for HCV is available for all genotypes: 1, 2, 3, 4, 5 and 6

☐ **TECHNIVIE + ribavirin** 12 Weeks duration
(12.5mg Ombitasvir, 75mg Paritaprevir, 50mg Ritonavir)
Genotype 4 without cirrhosis
Take 2 tabs PO once daily (AM) with food

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee.
PLEASE NOTE: Enexia Specialty Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

Please fax completed form to **Enexia Specialty Pharmacy** at **(718) 360-9655**