Hepatitis C Prescription Form

CIENEGA PHARMACY
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DATE:_____ NEEDS BY DATE:_____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
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	_____
❑ 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® Prefilled Syringe	Inject: ❑ 180mcg subcutaneously weekly ❑ 135mcg subcutaneously weekly ❑ 90mcg subcutaneously weekly	28 day supply	_____
❑ Pegasys® ProClick		28 day supply	_____
❑ Peg-Intron® Redipen	Inject: ❑ 180mcg subcutaneously weekly ❑ 135mcg subcutaneously weekly		

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

		28 day supply	_____
❑ 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 **Please indicate previously failed therapy (Lactulose) _____	30 day supply	_____
❑ Other _____			

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

_____ _____

Prescriber's Signature (no stamps) Date

If Brand required check ❑ DAW