

Need By Date: _____ Ship To: Patient Office Other _____ Fax Copy: Rx Card Front/Back Clinical Notes Medical Card Front/Back

Patient Information		Prescriber Information		
Patient Name		Prescriber Name		
Address		Address		
City State ZIP		City State ZIP		
Main Phone	Alternate Phone	Phone	Fax	
Social Security #		Contact Person		
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	DEA #	NPI #	License #

Clinical Information				
Chronic Hepatitis C: <input type="checkbox"/> B18.2 Hepatic Encephalopathy: <input type="checkbox"/> K72.90 <input type="checkbox"/> K72.91 Hepatocellular Carcinoma: <input type="checkbox"/> C22.0 <input type="checkbox"/> C22.2 <input type="checkbox"/> C22.7 <input type="checkbox"/> C22.8				
<input type="checkbox"/> Other: _____				
Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 1a (NS5A RAVs: <input type="checkbox"/> No <input type="checkbox"/> Yes) <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		Viral Load	IU/mL	Viral Load Date
<input type="checkbox"/> Treatment Naive <input type="checkbox"/> Previously Treated (prior treatment used): _____ <input type="checkbox"/> Non-Responder <input type="checkbox"/> Responder/Relapser				
Duration of Previous Therapy: _____ / _____ / _____ to _____ / _____ / _____ Total of: _____ months				
HIV Coinfected: <input type="checkbox"/> No <input type="checkbox"/> Yes	HBV Coinfected: <input type="checkbox"/> No <input type="checkbox"/> Yes	Solid Organ Transplant Recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	Awaiting Liver Transplant: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Cirrhosis: <input type="checkbox"/> No <input type="checkbox"/> Yes				
If cirrhotic, is patient <input type="checkbox"/> Compensated or <input type="checkbox"/> Decompensated; MUST provide: albumin _____ g/dL, total bilirubin _____ mg/dL, and INR _____				
Drug Allergies	Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs	METAVIR Score	Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing	

Prescription Information			Qty	Refills
<input type="checkbox"/> Doptelet®	20 mg Tablet	<input type="checkbox"/> Take 2 tablets (40 mg total) by mouth once daily for 5 days <input type="checkbox"/> Take 3 tablets (60 mg total) by mouth once daily for 5 days *DOPTELET® should be initiated 10 to 13 days prior to scheduled procedure date	10 15	_____ _____
<input type="checkbox"/> Epclusa®	sofosbuvir and velpatasvir 400 mg/100 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Harvoni®	ledipasvir and sofosbuvir 90 mg/400 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Mavyret®	glecaprevir/pibrentasvir 100 mg/40 mg Tablet	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	28 Day Supply	_____
<input type="checkbox"/> Ribavirin	200 mg <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule	<input type="checkbox"/> 600 mg AM and 600 mg PM (1200 mg) <input type="checkbox"/> 600 mg AM and 400 mg PM (1000 mg) <input type="checkbox"/> 400 mg AM and 400 mg PM (800 mg) <input type="checkbox"/> 400 mg AM and 200 mg PM (600 mg) <input type="checkbox"/> Other: Take _____ mg AM and _____ mg PM	28 Day Supply	_____
<input type="checkbox"/> Sovaldi®	400 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Vosevi™	sofosbuvir, velpatasvir, voxilaprevir 400 mg/100 mg/100 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	28 Day Supply	_____
<input type="checkbox"/> Xifaxan	550 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily Indicate previously failed therapy: <input type="checkbox"/> Lactulose <input type="checkbox"/> Other _____	30 Day Supply	_____
<input type="checkbox"/> Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted

Date

Prescriber's Signature (no stamps) Dispense As Written

Date