BioPlus® Specialty Pharmacy
A Carelon Company

Hepatology

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com/therapy

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

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Chronic Hepatitis C: ☐ B18.2 Hepatic Encephalopathy: ☐ K72.90 ☐ K72.91 Hepatocellular Carcinoma: ☐ C22.0 ☐ C22.2 ☐ C22.7 ☐ C22.8

☐ Other: _____

Genotype: ☐ 1 ☐ 1a (NS5A RAVs: ☐ No ☐ Yes) ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	Viral Load IU/mL	Viral Load Date

☐ Treatment Naive ☐ Previously Treated (prior treatment used): _____ ☐ Non-Responder ☐ Responder/Relapser

Duration of Previous Therapy: _____ / _____ / _____ to _____ / _____ / _____ Total of: _____ months

HIV Coinfected: ☐ No ☐ Yes	HBV Coinfected: ☐ No ☐ Yes	Solid Organ Transplant Recipient: ☐ No ☐ Yes	Awaiting Liver Transplant: ☐ No ☐ Yes

Cirrhosis: ☐ No ☐ Yes

If cirrhotic, is patient ☐ Compensated **or** ☐ Decompensated; MUST provide: albumin _____ g/dL, total bilirubin _____ mg/dL, and INR _____

Drug Allergies	Weight ☐ kg ☐ lbs	METAVIR Score	Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Doptelet®	20 mg Tablet	☐ Take 2 tablets (40 mg total) by mouth once daily for 5 days ☐ 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	_____ _____
☐ Epclusa®	sofosbuvir and velpatasvir 400 mg/100 mg Tablet	☐ Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
☐ Harvoni®	ledipasvir and sofosbuvir 90 mg/400 mg Tablet	☐ Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
☐ Mavyret®	glecaprevir/pibrentasvir 100 mg/40 mg Tablet	☐ Take 3 tablets by mouth once daily with food	28 Day Supply	_____
☐ Ribavirin	200 mg ☐ Tablet ☐ Capsule	☐ 600 mg AM and 600 mg PM (1200 mg) ☐ 600 mg AM and 400 mg PM (1000 mg) ☐ 400 mg AM and 400 mg PM (800 mg) ☐ 400 mg AM and 200 mg PM (600 mg) ☐ Other: Take _____ mg AM and _____ mg PM	28 Day Supply	_____
☐ Sovaldi®	400 mg Tablet	☐ Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
☐ Vosevi™	sofosbuvir, velpatasvir, voxilaprevir 400 mg/100 mg/100 mg Tablet	☐ Take 1 tablet by mouth once daily with food	28 Day Supply	_____
☐ Xifaxan	550 mg Tablet	☐ Take 1 tablet by mouth twice daily Indicate previously failed therapy: ☐ Lactulose ☐ Other _____	30 Day Supply	_____
☐ Other				

Prescriber's Signature (no stamps) **Substitution Permitted** _____ **Date** _____

Prescriber's Signature (no stamps) **Dispense As Written** _____ **Date** _____