VERBAL ORDER FORM
HEPATOLOGY

1642 Eastchester Rd, Bronx, NY 10461
Ph 347-691-3494 | Fax 347-691-3496
NPI# 1003148321 NCPDP# 3364471
info@QuickRxSpecialty.com

QuickRX SPECIALTY PHARMACY

Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRx Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code ☐ **B18.2 HCV** (Chronic) ☐ Other_____ ☐ relapsed ☐ partial response ☐ null response
Previously treated for this condition? ☐ No ☐ Yes, what drugs_____
Interferon? ☐ Yes ☐ No # of Weeks_____ (IU)Date of Labs_____ ALT_____ AST_____ Hgb_____
HCV MEDICAL CRITERIA Genotype_____ HCV-Viral Load_____ eGFR _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **EPCLUSA®** 400mg / 100mg tablet (brand) ☐ **DAW**
☐ **SOFOSBUVIR/VELPATASVIR** 400mg / 100mg tablet (generic)
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **HARVONI®** 90mg / 400mg tablet (brand) ☐ **DAW**
☐ **LEDIPASVIR/SOFOSBUVIR** 90mg / 400mg tablet (generic)
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **MAVYRET™** 100mg glecaprevir / 40mg pibrentasvir tablet
Therapy Length: ☐ 8 weeks or ☐ 12 weeks
SIG: Take 3 tablets orally once daily with food QTY: 84 Refill: _____

☐ **PEGASYS®**
SIG: ☐ ProClick 135mcg Autoinjector Inject SQ weekly
☐ ProClick 180mcg Autoinjector Inject SQ weekly
☐ Pre-Filled Syringe 180mcg / 0.5ml Inject SQ weekly
☐ Other _____
QTY: ☐ 1 month ☐ 3 month Refill: _____

☐ **PEG INTRON®** ☐ **REDIPEN** ☐ **VIAL**

Weight (lbs)	Strength (Dose)	Amount to inject	Volume to inject
☐ < 88	50 mcg per 0.5 mL	50 mcg	0.5 mL
☐ 88 - 111	80 mcg per 0.5 mL	64 mcg	0.4 mL
☐ 112 - 133		80 mcg	0.5 mL
☐ 134 - 144	120 mcg per 0.5 mL	96 mcg	0.4 mL
☐ 145 - 166		96 mcg	0.4 mL
☐ 167 - 177		120 mcg	0.5 mL
☐ 178 - 187			
☐ 188 - 231	150 mcg per 0.5 mL	150 mcg	0.5 mL
☐ >231	***	***	***

***Dose of 1.5 mcg/kg/week should be calculated based on patient weight.
Two vials of Peg Intron may be necessary to provide the dose.

QTY: ☐ 1 month ☐ 3 month Refill: _____

RIBAVIRIN® ☐ 200mg capsule ☐ 200mg tablet Patient Weight (kg) _____
SIG: _____ QTY: _____ Refill: _____

☐ **SOVALDI®** sofosbuvir 400mg tablet
SIG: 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*)
☐ Other: _____
QTY: 28 Refill: _____

☐ **VOSEVI™** 400mg sofosbuvir/100mg velpatasvir/100mg voxilaprevir tablet
SIG: Take 1 tablet by mouth daily with food for 12 weeks
QTY: 28 Refill: 2

☐ **ZEPATIER™** grazoprevir 100mg / elbasvir 50mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

HEPATITIS B ORAL THERAPIES
☐ **BARACLUDE®** ☐ 0.5mg ☐ 1.0mg
☐ **EPIVIR® HBV** 100mg ☐ **HEPSERA®** 10mg
☐ **VEMLIDY®** 25mg ☐ **VIREAD®** 300mg
SIG: _____ QTY: _____ Refill: _____

☐ Include 25G 1/2" syringes and alcohol pads with all injectables
☐ **NEUPOGEN®** ☐ 300mcg PFS ☐ 480mcg PFS
☐ 300mcg VIAL ☐ 480mcg VIAL
☐ **PROCRIT®** ☐ 10,000IU ☐ 20,000IU ☐ 40,000IU
SIG: _____ QTY: _____ Refill: _____

☐ **XIFAXAN®** ☐ 200mg ☐ 550mg
☐ 1 200mg TAB PO TID x 3 Days QTY: 9 Refill: _____
☐ 1 550mg TAB PO BID QTY: 60 Refill: _____
☐ 1 550mg Tab PO TID x 14 Days QTY: 42 Refill: _____
☐ **RELISTOR®** ☐ 8mg PFS ☐ 12mg PFS ☐ 150mg tablet
SIG: _____ QTY: _____ Refill: _____

OTHER MEDICATION_____
SIG:_____ **QTY**:_____ **REFILL**:_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

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

By signing this form and utilizing our services, you are authorizing QuickRx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.