BioTek reMEDys

Anti-Hepatitis C Prescription/Referral Form

Please complete this form (Print) in it's entirely. Be sure to include any necessary documentation, labs, insurance cards, etc

2 Penns Way, Ste# 404
New Castle, DE 19720
Tel: (877)246-9104
Fax: (302)544-5018
www.biotekrx.com

Ship to: ☐Patient ☐Office ☐Other: **Date need by:** _____

*marked information is necessary **Patient Information**

*Patient Name:_____

*Address: _____

*City,State,Zip:_____

*Home Phone:_____

*Alternate Phone:_____

*SSN#(At least last four digits)_____-_____-_____

*Allergies:_____

*Date of Birth:_____ *Gender:_____ *Weight: ____lbs____kg

Patient ethnicity:_____ ☐ See attached demographic sheet

Prescriber Information

Prescriber's Name:

State License #:
NPI: on file
Address:

Phone:
Fax:
Contact Person: _____

INSURANCE INFORMATION (Please copy and attach copy of insurance and prescription card)

*Primary Insurance: _____
City:_____ State:_____
Plan #: _____
Group #: _____
Phone: _____

*Rx Card (PBM): _____
*PBM BIN:_____ *PCN: _____
City: _____ State:_____
*Group#: _____ *ID#_____
*Phone: _____

EMERGENCY CONTACT INFORMATION

*Contact Name _____

*Phone:_____

*Primary, Emergency, or Both_____

***CLINICAL AND PRESCRIPTION INFORMATION**

☐ **070.54 Hepatitis C (chronic)** ☐ **Other ICD 9** _____ **Genotype:** ☐**1** ☐**1a** ☐**1b** ☐**2** ☐**2a** ☐**2b** ☐**3** ☐**3a** ☐**3b** ☐**4** ☐**4a** ☐**4b** ☐**5** ☐**6** ☐ **Other** _____

Viral Code: _____ ☐ Treatment Naïve ☐ Previous treatment: _____ ☐ Non-Responder ☐ Partial Responder ☐ Responder/Relapser

Duration of prior treatment: From _____ To_____ Total of _____ Weeks Co-infected with ☐HIV ☐HBV ☐N/A Cirrhosis: ☐Compensated ☐De-Compensated

History of liver biopsy? ☐Yes ☐No ☐N/A Fibrosis present? ☐Yes ☐No ☐N/A History of liver test? ☐Yes ☐No ☐N/A Fibro score:_____ ☐N/A Il28B genotype_____

- Labs: to be preformed prior to therapy and monitored during treatment at appropriate intervals (particularly pregnancy test for woman of childbearing potential) ALT ____ AST____ Hgb____ Plt____
- Other medications patient is currently taking (including OTC medications):

  _____
- Other disease states: ☐Depression ☐Anxiety ☐Diabetes ☐Other

Prescription		Quantity		Refill
☐ **Daklinza®** (daclatasvir)	☐ Take 30 mg by mouth once daily ☐ Take 60 mg by mouth once daily ☐ Take 90 mg by mouth once daily	☐ 28 x 30 mg tablets ☐ 28 x 60 mg tablets ☐ 28 x 90 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐ Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	☐ 12 weeks	_____
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	_____
☐ **Olysio®** (simeprevir)	☐ Take 150 mg by mouth once daily	☐ 28 x 150 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Sovaldi®** (sofosbuvir)	☐ Take 400 mg by mouth once daily	☐ 28 x 400 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Technivie™** (ombitasvir/paritaprevir/ritonavir)	☐ Take 2 tablets in the morning by mouth with food	☐ 56 x tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Viekira Pak™** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets in the morning and 1 tablet in the evening by mouth with food	☐ 112 tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Zepatier™** (elbasvir/grazoprevir)	☐ Take 50 mg/100 mg by mouth once daily	☐ 28 tablets	☐ 12 weeks ☐ 16 weeks	_____
☐ **Pegasys®** (peginterferon alfa-2a)	☐ Inject 180 mcg subcut once weekly ☐ _____	☐ 4 x 180 mcg	☐ PFS ☐ Autoinjector	_____
☐ **Ribasphere® Ribapak® Dose Pak** (ribavirin) ☐ **Moderiba™ Dose Pack** (ribavirin)	☐ Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	☐ 28 x 200 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 600 mg ☐ 28 x 600 mg; 28 x 600 mg	Tablets	_____
☐ **Ribasphere®**** (ribavirin)		☐ _____ x 200 mg	☐ Tablets ☐ Capsules	_____

***For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availiability (or insurance preference) will be dispensed.*

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

I authorize Biotek Remedys to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate di-identified data for market analysis, and provide educatioal information regarding therapies. I understand that I may revoke this authorizaion anytime in writing by sending a letter to Biotek Remedys 2 Penns Way, Suite 404 New Castle, DE 19720. I understand that a copy of this authorization will be utilized with the same effectivness as the original.

Patient Signature *(required for participation):*_____ Date:_____

Physician's Signature: _____ **Dispense as Written** **Date** ____ /____ /____

Fax completed form to: (302) 544-5018 Thank you for using BioTek reMEDys!