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

Tel: (877) 246-9104
Fax: (888) 963-8122
www.biotekrx.com

Ship to: ☐Patient ☐Office ☐Other: Date need by:________________________________

Patient Information

Patient Name:____
Address: ____
City,State,Zip:____
Home Phone:____
Alternate Phone:____
SSN#_______-________-_________ Allergies:______________________
Date of Birth:_______________Gender:_________ Weight: ____lbs ____kg
Patient ethnicity:______________ ☐ See attached demographic sheet

Prescriber Information

Prescriber's Name:

State License #: on file
NPI: on file
Address: on file

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#: _________________________
Phone: __________________________

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________________

☐ **HARVONI**
Dosage : 90/400 tablet QD

·Treatment – naïve with or without cirrhosis: 12 weeks
·Treatment – experienced without cirrhosis :12 weeks
·Treatment - experienced with cirrhosis: 24 week

28 Day Supply
Refills _____

☐ **OLYSIO** (simeprevir) 150mg
Dosage: 150mg (capsule) QD with food Qty: 28 day supply
Refills:________

____

☐ **Viekira Pak** (ombitasvir, paritaprevir, and ritonavir; dasabuvir); **for oral use**

Dosage: 12.5/50/75 mg (pink tablets); 250 mg (beige tablets)

Qty: 28 day supply Refills:_____________

Take two pink tablets once daily in the AM and one beige tablet twice daily in the AM and PM with food

Note: Ribavirin dosing is weight based (source: Schering) – It is not based on individual Ribavirin package insert

☐ **Ribapak (Ribavirin dose pack: one AM tab and one PM tab)**
☐ **Other**: ______________________________

Protease/Polymerase Inhibitor

☐ **SOVALDI** (sofosbuvir)
Dosage: 400mg tablet QD Qty: 28 Day Supply Refills: _______

☐ Daklinza (declatasvir) Dosage: ☐ 60mg ☐ 30mg Refills _____
Quantity: 28 Days supply

HCV Genotype: 3 Regimen Daklinza and Sovaldi Refills x 2

Technivie® (ombitasvir, paritaprevir, ritonavir)	Pak contains: ombitasvir paritaprevir, ritonavir: 12.5/75/50 mg	☐ Take 2 tablets every morning with food daily for 12 weeks ☐ Other: ____________	☐ 1-month supply ☐ 3-month supply ☐ Other ______ Refills _______
Zepatier™ (elbasvir/ grazoprevir)	50 mg elbasvir and 100 mg grazoprevir NS5A resistant polymorphisms: __ Yes __No	☐ Take one tablet daily with or without food ☐ Other ____________ Duration: __12 weeks __ 16 weeks __Other________	☐ 1-month supply ☐ 3-month supply ☐ Other ______ Refills _______

Intended combination therapy duration: ☐12 Weeks ☐24 Weeks ☐36 Weeks ☐48 Weeks ☐ Other________

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 ____ /____ /____

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (888) 963-8122. Thank you for using BioTek reMEDYs!