Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select Zarina Pharmacy from your EHR

HEPATITIS C

Fax 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female ○ Male	
Email:		Allergies:			

INSURANCE INFORMATON (or attach copy of cards)

Primary Insurance:	Phone:	Policy #:	Group #:
Secondary Insurance:	Phone:	Policy #:	Group #:

CLINICAL INFORMATION (attached copy of labs)

Primary Diagnosis (ICD-10):	Secondary Diagnosis (ICD-10):

Responder status:
☐ Treatment Naïve ☐ Treatment Experienced

Prior Treatment Type: _____

_____

_____

Did patient fail NS5A based treatment (Harvoni, Daklinza, Viekira, Zepatier)?
☐ No ☐ Yes (Please include RAV)

Comorbidities:
☐ ESRD ☐ HIV ☐ HBV ☐ Diabetes
☐ Other_____

Fibrosis Stage:

_____

Child-Pugh Score:

_____

HCV genotype:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 1a ☐ 2a
☐3a ☐ 4a ☐ 1b ☐ 2b ☐ 3b ☐ 4b
☐ Other _____

HCV RNA: _____

Cirrhosis: ☐ Y ☐ N
If YES:
☐ Compensated ☐ Decompensated

Test Type	GT1 NS5A RAV Test	Genotype + GT1a RAV (reflex) panel	Viral Load + GT1a RAV (reflex) panel	Viral Load + Genotype (reflex) + GT1a RAV (reflex) panel
Quest Lab	92447(X)	93871(X)	N/A	93873(X)
LabCorp	550325	550615	93873(X)	550705

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	SIG/DIRECTIONS:	QUANTITY	REFILLS
☐ **EPCLUSA®** (sofosbuvir 400 mg/ velpatasvir 100 mg)	Take one tablet PO daily	28 Day Supply	
☐ **HARVONI®** (ledipasvir 90 mg/ sofosbuvir 400 mg)	Take one tablet PO daily	28 Day Supply	
☐ **MAVYRET™** (glecaprevir/ pibrentasvir)	Take three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) PO daily with food	28 Day Supply	
☐ **RIBAVIRIN** 200 mg	Take _____ mg AM and _____ mg PM	28 Day Supply	
☐ **VOSEVI™**((sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg)	Take one tablet PO daily with food	28 Day Supply	
☐ **ZEPATIER®** (elbasvir 50 mg/ grazoprevir 100 mg)	Take one tablet PO daily with food	28 Day Supply	
☐ **Other**			

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	
Office Contact:	Email:		
Address:	City:	State:	ZIP:
NPI #:	Tax ID #:	Ship To: ☐ Patient ☐ MD Office	
Prescriber Signature:	Date:		