Zarina Pharmacy
SPECIALTY & INFUSION

Hepatology

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

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				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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

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