VERBAL ORDER FORM
HEPATOLOGY

398 W. Grand Avenue | Rahway, NJ 07065
Ph 844-527-9486 | Fx 866-285-7628
NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPRx.com

Today's Date ______________
Date Needed ______________

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

Patient Name______________________ Date of Birth__________ ☐ Male ☐ Female
Address______________________ Apt #_____ City__________ State_____ Zip_______
Telephone__________ Cell__________ SSN__________ Email__________
Allergies______________________ Comorbidities______________________
Current Medications (if necessary, please fax a complete list)______________________

Primary Insurance______________________ ID#__________ Group #__________
Insured's Name______________________ Employer______________________
City__________ State_____ Phone__________

ICD-10 Code ☐ B18.2 HCV (Chronic) ☐ Other ________ ☐ relapsed ☐ partial response ☐ null response
Previously treated ☐ 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**__________

Y21 IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary 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.

Please fax completed referral form to **PFSP** at **866-285-7628**
Visit us at **PFSPrx.com** for online fillable forms.
Scan our QR Code to send us feedback about your experience.