PFSP

@pfsprx #pfsprx

VERBAL ORDER FORM
INFECTIOUS DISEASE

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 ____________

Primary Insurance ____________ ID# ____________ Group # ____________
Insured's Name ____________ Employer ____________
City ____________ State ______ Phone ____________

ICD-10 Diagnosis Code: ☐ B20 HIV/AIDS ☐ R64 Cachexia (HIV Wasting) ☐ B18.2 Hepatitis C (chronic)
☐ B18.1 Hepatitis B ☐ HIV-Infected patients with abdominal lipodystrophy ☐ Other ____________
CD4 count ______ Viral Load/HIV RNA ______ Hgb/Hct ______ WBC/ANC ______ CrCl ______ (Please include copy of most recent labs)
Has patient been on therapy and relapsed? ☐ Yes ☐ No List of medication(s) ____________
Is patient currently on therapy? ☐ Yes ☐ No List of medication(s) ____________
Will patient stop taking the medication(s) before or when starting the new medication? ☐ Yes ☐ No
List of medication(s) to be discontinued (Note: Fuzeon® must be taken as part of a combination antiviral regimen) ____________
Current medications patient (including OTC) with dosage and direction (or fax medication) ____________

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE/NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS

DESCOVY® ☐ 200mg/25mg
EMTRIVA® ☐ 200mg ☐ 10mg/mL Sol
EPIVIR® ☐ 150mg ☐ 300mg ☐ 10mg/mL Sol
RETROVIR® ☐ 100mg tab ☐ 300mg tab ☐ 10mg/mL Syrup
VIDEX® EC ☐ 125mg ☐ 200mg ☐ 250mg ☐ 400mg
Plain Videx Solution ☐ 4 gram ☐ 2 gram
VIREAD® ☐ 300mg
ZERIT® ☐ 15mg ☐ 20mg ☐ 30mg ☐ 40mg ☐ 1mg/mL Sol
ZIAGEN® ☐ 300mg ☐ 20mg/mL Sol
QTY: ______ Refill: ______ SIG: ____________

COMBINATION ANTIRETROVIRALS

ATRIPLA® ☐ 600/200/300mg
BIKTARVY® ☐ 50/200/25mg
COMBIVIR® ☐ 150/300mg
COMPLERA® ☐ 200/25/300mg
DELSTRIGO™ ☐ 100/300/300mg
DOVATO™ ☐ 50/300mg
EPZICOM® ☐ 600/300mg
GENVOYA® ☐ 150/150/200/10mg
JULUCA® ☐ 50/25mg
ODEFSEY® ☐ 200/25/25mg
STRIBILD® ☐ 150/150/200/300mg
SYMTUZA™ ☐ 800/150/200/10mg
TRIUMEQ® ☐ 600/50/300mg
TRIZIVIR® ☐ 300/150/300mg
TRUVADA® ☐ 200/300mg
QTY: ______ Refill: ______ SIG: ____________

NON-NUCLEOSIDE ANALOGS

EDURANT® ☐ 25mg
INTELENCE™ ☐ 100mg ☐ 200mg ☐ 25mg
PIFELTRO™ ☐ 100mg
RESCRIPTOR® ☐ 100mg ☐ 200mg
SUSTIVA® ☐ 50mg cap ☐ 200mg cap ☐ 600mg tab
VIRAMUNE® ☐ 200mg ☐ XR 100mg ☐ XR 400mg
QTY: ______ Refill: ______ SIG: ____________

INTEGRASE INHIBITORS

ISENTRESS® ☐ 400mg ☐ 600mg
TIVICAY® ☐ 50mg
VITEKTA® ☐ 85mg ☐ 150mg
QTY: ______ Refill: ______ SIG: ____________

PROTEASE INHIBITORS

APTIVUS® ☐ 250mg ☐ 100mg/mL Sol
CRIXIVAN® ☐ 200mg ☐ 400mg
EVOTAZ™ ☐ 300mg/150mg
INVIRASE® ☐ 200mg ☐ 500mg
KALETRA® ☐ 100mg/25mg tab ☐ 200mg/50mg tab ☐ 80mg/20mg/mL Sol
LEXIVA® ☐ 700mg ☐ 50mg/ml Susp
NORVIR® ☐ 100mg Tab ☐ 80mg/mL ☐ 100mg Cap
PREZCOBIX™ ☐ 800mg/150mg
PREZISTA® ☐ 75mg ☐ 150mg ☐ 600mg ☐ 800mg ☐ 100mg/mL Susp
REYATAZ® ☐ 150mg ☐ 200mg ☐ 300mg
VIRACEPT® ☐ 250mg ☐ 625mg
QTY: ______ Refill: ______ SIG: ____________

FUSION INHIBITORS

FUZEON® ☐ 90mg QTY: ______ Refill: ______

PRE-EXPOSURE PROPHYLAXIS (for HIV PrEP)

TRUVADA® ☐ 200/300mg tablet
SIG: Take 1 tablet by mouth daily QTY: ______ Refill: ______
DESCOVY® ☐ 200/25mg tablet
SIG: Take 1 tablet by mouth daily QTY: ______ Refill: ______

POST-EXPOSURE PROPHYLAXIS (for HIV PEP)

TRUVADA® ☐ 200/300mg QTY: 28 Refills: 0
SIG: Take one tablet by mouth daily for four weeks
ISENTRESS® ☐ 400mg QTY: 56 Refills: 0
SIG: Take one tablet by mouth twice daily for four weeks

XERAVA® ☐ 50mg vial
SIG: Infuse ______ (1mg/kg dose) IV every 12 hours for ______ days (4-14 days) QTY: ______ vials Refill: ______

SIVEXTRO® ☐ 200mg tablet QTY: 6 Refill: ______
SIG: Take one tablet by mouth daily for 6 days
BAXDELA™ ☐ 450mg tablet QTY: ______ Refill: ______
SIG: Take one tablet by mouth twice daily for ______ days

☐ **BACTRIM®** ☐ **DIFLUCAN®** ☐ **SELZENTRY®**
☐ **MEGACE®** 40mg/mL ☐ **MEGACE® ES** 625mg/5ml
QTY: ______ Refill: ______ SIG: ____________

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

☐ **HARVONI®** ledipasvir 90mg/sofosbuvir 400mg
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: ______

☐ **EPCLUSA®** sofosbuvir 400mg/velpatasvir 100mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: ______

☐ **ZEPATIER™** grazoprevir 100mg/elbasvir 50mg tablet
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 by mouth once daily with food
QTY: 84 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

☐ **SOVALDI®** 400mg tablet QTY: 28 Refill: ______
SIG: Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks with Ribavirin (Genotype 2)
☐ 24 weeks with Ribavirin (Genotype 3)
☐ Other: ____________

RIBAVIRIN® ☐ 200mg cap ☐ 200mg tab Weight: ______ kg
QTY: ______ Refill: ______ SIG: ____________

HEPATITIS B ORAL THERAPIES

BARACLUDE® ☐ 0.5mg ☐ 1.0mg ☐ **EPIVIR® HBV** 100mg
☐ **HEPSERA®** 10mg ☐ **VEMLIDY®** 25mg ☐ **VIREAD®** 300mg
QTY: ______ Refill: ______ SIG: ____________

☐ 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
QTY: ______ Refill: ______ SIG: ____________

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
QTY: ______ Refill: ______ SIG: ____________

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.