GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____

HEPATITIS C PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION – Please, provide most recent lab report

ICD-9 Code: ☐ 070.54 Hepatitis C Genotype: _____ ☐ _____ ☐ ALT: _____ ☐ AST: _____ ☐ Viral Load HCV RNA: _____
Weight: _____ lbs / kg Allergies: _____ Please circle: Naive Patient / Non-Responder / Relapsed Patient

PRESCRIPTION INFORMATION

☐ **INITIAL PRESCRITION** ☐ **PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Incivek®	☐ 375mg	☐ Take 2 tablets PO TID (7-9 hours apart) ; each dose with 20g fat	168	
☐ Victrelis®	☐ 200mg	☐ Take 4 capsules (800mg) PO TID with food	336	
☐ Pegasys® ☐ PFS ☐ Pro-click	☐ 180mcg ☐ 135mcg	☐ 90mcg SQ once weekly ☐ 180mcg SQ once weekly ☐ 135mcg SQ once weekly	28 d	
☐ Peg-Intron Redipen®	☐ <88 lbs: 50mcg/0.5ml: 50mcg SQ once weekly ☐ 134-165 lbs: 120mcg/0.5ml : 96mcg SQ once weekly ☐ 88-110 lbs: 80mcg/0.5ml: 64mcg SQ once weekly ☐ 167-187 lbs: 120mcg/0.5ml : 120mcg SQ once weekly ☐ 112-132 lbs: 80mcg/0.5ml: 80mcg SQ once weekly ☐ >187 lbs: 150mcg/0.5ml : 150mcg SQ once weekly		28 d	
☐ Procrit®	☐ 20,000 U/ml : 20,000U SQ once weekly ☐ 30,000 U/ml : 30,000U SQ once weekly ☐ 40,000 U/ml : 40,000U SQ once weekly		28 d	
☐ RibaPak®	☐ 600mg dose pack	☐ 200mg every AM, 400mg every PM ☐ 600mg every AM, 400mg every evening ☐ 400mg every AM, 400mg every PM ☐ 600mg every AM, 600mg every evening	28 d	
☐ Ribarivin (generic)	☐ 200mg			

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐ **Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____

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Date: _____

HEPATITIS B PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
Address: _____ Date of Birth: _____
City, State,Zip: _____ SSN: _____
Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home
☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: ☐ 070.3 Hepatitis B ☐ _____ ☐ New Therapy ☐ Continued Therapy ***Start Date***: _____
ALT: _____ HBV DNA (Viral Load) : _____ Weight: _____lbs / kg

Most recent Lab date: _____
☐ HBeAg : + / -
☐ HBeAb : + / - (+: reactive/ -: non)
☐ HBsAg : + / -

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Baraclude®	☐ 0.5mg ☐ 1.0 mg	☐ Take 1 tablet by mouth daily ☐ Other: _____	30 d ☐___	
☐ Epivir HBV®	☐ 100mg ☐ 150mg ☐ 300mg			
☐ Hepsera®	☐ 10mg			
☐ Tyzeka®	☐ 600 mg			
☐ Viread®	☐ 300mg			
☐ Pegasys® ☐ PFS ☐ Pro-click	☐ 180mcg ☐ 135mcg	☐ 90mcg SQ once weekly ☐ 180mcg SQ once weekly ☐ 135mcg SQ once weekly	28 d	
☐ HBIG (Hepatitis B Immune Globulin – single use vial)				

☐ Other medication:

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Patient Signature: _____ **Date:** _____