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| --- |
| Attention:                                     Need By Date:                 First Ship To: [ ]  Patient [ ]  Physician |
| **Patient** | Patient Name:                                    DOB:                 Sex: [ ]  Male [ ]  Female Address:                                     City:                      State:                 Zip:           Home#:                 Work #:                 Cell#:                 Best time to call: [ ]  AM [ ]  PMSoc. Sec #:           -          -           Ethnicity:                 Primary Language:                Comorbidities:                      Height:            Weight:           Date:          Allergies:                                                              [ ]  NKDA |
| **Provider** | Physician Name:                     Practice Name:                State Lic#:            DEA#:           Address:                          City:                State:           Zip:           NPI#:           Phone#:                 Fax#:                 Nurse/Key Office Contact:                 Ext.:            |
| **Insurance** | Primary Insurance:                      ID:                      Phone:                     Secondary Insurance:                      ID:                      Phone:                     \* Please provide a copy of the insurance card (front and back) and MEDICATION LIST |
| **Clinical Info** | Diagnosis/ICD-10: 318.2 HCV (chronic) other:                | Genotype/Subtype:                /                |
| Patient type: [ ]  naïve [ ]  relapse [ ]  partial responder [ ]  null responder | For genotype 1a, is the Q80K polymorphism present? [ ]  Yes [ ]  No |
| Cirhosis: [ ]  Yes [ ]  No if yes, is it: [ ]  compensated [ ]  decompensated | Baseline Viral Load:                           IU/ml |
| Metavir score: [ ]  F0 [ ]  F1 [ ]  F2 [ ]  F3 [ ]  F4 | Fibroscan™ :                 kPa FibroSURE® :                 |
| Activity: [ ]  A0 [ ]  A1 [ ]  A2 [ ]  A3 | Is patient awaiting liver transplantation for hepatocellular carcinoma?  |
| Child Pugh Score: [ ]  A [ ]  B [ ]  C | [ ]  Yes [ ]  No |
| Is the patient interferon-intolerant? [ ]  Yes [ ]  No |  |
| **Prescription** |
| **Medication** | **Strength** | **Directions** | **Quantity** | **Refill** |
| **[ ]  Daklinza®** | [ ]  60 mg[ ]  30 mg\* | Take 1 tablet by mouth once daily with or without food\*30 mg dose is utilized when given in combination with strong CYP3A inhibitors. 90 mg dose is to be administered when given in combination with moderate inducers of CYP3A. | 28 days supply |       |
| **[ ]  Harvoni®****(ledipasvir/sofosbuvir)** | 90 mg/400 mg | Take 1 tablet by mouth once daily with or without food | 28 days supply |       |
| **[ ]  Sovaldi®** | 400 mg | Take 1 tablet by mouth once daily | 28 days supply |       |
| **[ ]  Technivie™****(ombitasvir, paritaprevir, ritonavir)** | 12.5/75/50 mg | Take 2 tablets by mouth once daily in the morning with a meal | 28 days supply |       |
| **[ ]  Viekira™ Pak****(ombitasvir, paritaprevir, ritonavir, dasaburvir)** | 12.5/75/50/250 mg | Take 2 ombitasvir/ paritaprevir/ ritonavir tablets once daily (in the morning) and 1 dasaburvir tablet twice daily (morning and evening) | 28 days supply |       |
|  **[ ]  Pegasys®**  **ProClick™** **PFS** **Vial** | [ ]  180 mcg[ ]  135 mcg[ ]  ProClick™ only | Inject 180 mcg Sub-Q once weeklyInject 135 mcg Sub-Q once weeklyOther                                | 28 days supply |       |
| **[ ]  Pegintron® Vial** | [ ]  50 mcg/0.5 ml[ ]  80 mcg/0.5 ml[ ]  120 mcg/0.5 ml[ ]  150 mcg/0.5 ml | Inject            mcg\* Sub-Q once weekly\* Dosed at 1.5 mcg/kg | 28 days supply |       |
| **[ ]  Moderiba™ Dose Pack****[ ]  RibaPak® Dose Pack** | [ ]  600 mg/600 mg[ ]  600mg/400mg | Take 600 mg by mouth in the morning and 400 mg by mouth in the eveningTake 600 mg by mouth in the morning and 600 mg by mouth in the eveningOther:                                | 28 days supply |       |
| **[ ]  Moderiba™ Tabs****[ ]  Ribavirin/Ribasphere®** **[ ]  Capsule [ ]  Tablet** | 200mg | 28 days supply            |       |
| Physicians Signature:                                Date:                I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. |