IRVINGTON PHARMACY

HEPATITIS C REFERRAL FORM

1070 Springfield Ave, Irvington, NJ 07111
Phone : 862-255-2804 | Fax : 860-229-2417
E-mail : irvingtonpharmacy@gmail.com

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name | DOB | Weight | ☐ Male ☐ Female

Street Address | Apt # | City | State | Zip

Evening Tel | Cell. | ☐ Text Message Allowed Email

Caregiver Name | Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physican Office ☐ Pharmacy

Allergies | Comorbiditie

Current Medications (if necessary, please fax a complete list)

Previously treated ☐ No ☐ Yes, what drugs | Interferon ☐ Yes ☐ No # of weeks | ☐ relapsed ☐ partial responce ☐ null responce

ICD-9 Code ☐ 070.54HCV (Chronic) Genotype | Subtype | Liver Biospsy ☐ Yes ☐ No Date | Results

Other Lab Results ALT | Date | AST | Date | Hgb | Date | HCV RNA | Date

Prescriber's Name | Office Contact

Street Address | Suite # | City | State | Zip

Tel | Fax | Email

License# | NPI# | UPIN# | DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PEG INTRON REDIPEN

Weight (lbs)	Strength	Amounr to Inject	Volume to Inject
☐ < 88	50 mcg /0.5 mL	50 mcg	0.5 mL SQ Weekly
☐ 88 - 111	80 mcg /0.5 mL	64 mcg	0.5 mL SQ Weekly
☐ 112 - 133		80 mcg	0.5 mL SQ Weekly
☐ 134 - 144	120 mcg /0.5 mL	96 mcg	0.5 mL SQ Weekly
☐ 145 - 166		96 mcg	0.5 mL SQ Weekly
☐ 167 - 177		120 mcg	0.5 mL SQ Weekly
☐ 178 - 187		120 mcg	0.5 mL SQ Weekly
☐ 188 - 231	150 mcg /0.5 mL	150 mcg	0.5 mL SQ Weekly

Quantity : ☐ 28 days (4 pens) Refill x

PEGASYS

☐ ProClick 135mcg Autoinjector (NDC 004-.365-30) Inject SQ wekly
☐ ProClick 135mcg Autoinjector (NDC 004-.365-30) Inject SQ wekly
☐ Pre-Filled Syringe 180mcg/0.5ml (NDC 004-.365-30) Inject SQ wekly
☐ Other

Quantity : ☐ 28 days (4 pens) Refill x

☐ RIBAPAK ☐ MODERIBA

Please write DAW in this box

Qty 28 dys Refill x

Weight (lbs)	Doding	
☐ <87 - 144	800mg/day	400mg QAM 400mg QPM
☐ 145 - 188	1000mg/day	600mg QAM 400mg QPM
☐ 189 - 231	1200mg/day	600mg QAM 600mg QPM

☐ RIBASPHERE ☐ RIBAVIRIN

☐ 800mg 2QAM 2QPM QTY 112 ☐ 1000mg 2QAM 3QPM QTY 140
☐ 1200mg 3QAM 3QPM QTY 168 ☐ 1400mg 3QAM 4QPM QTY 196
☐ Other ☐ QAM ☐ QPM QTY ☐ Refill x

OLYSIO

(Simeprevir) ☐ 150mg capsule QTY Refill x
Take 1 capsule with food daily for 12 wks w/peginterferon and ribavirin

SOVALDI

(Sofosbuvir) 400mg tablet QTY Refills
Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks w/ Ribavirin (Genotype 2) 24 weeks with Ribavirin (Genotype 3)

VICTRELIS

☐ 800mg (4 x 200mg) QTY 28 Days (336 caps) Refill x
Directions: 3x daily with food, start day 29 of peginterferon and ribavirin

RIBAPAK

Dose Reduction 28 Day Supply Refills x
600mg/day 200mg QAM 400mg QPM

HARVONI

☐ Ledipasvir 90mg / Sofosbuvir 400mg
Take 1 tablet by mouth daily 28 Day Supply Refills x

INFERGEN

Qty Refill x
☐ 9mcg Sub-Q TIW QTY 12
☐ 15mcg Sub-Q TIW QTY 12
☐ 9mcg Sub-Q QD QTY 28
☐ 15mcg Sub-Q QD QTY 28
☐ Other

SUPPORTIVE THERAPIES

☐ Procrit ☐ Epogen
☐ Neulasta ☐ Aranesp ☐ Neupogen
Strength Qty Refill x
Directions

HEPATITIS B ORAL THERAPIES

☐ Baraclude ☐ 0.5mg ☐ 1.0mg ☐ Epivir HBV 100mg
☐ Hepsara 10mg ☐ Tyzeka 600mg
1 Tablet po QD Additional Directions:
Quantity ☐ 1 Month ☐ 3 Month

Prescriber's Signature signature required. NO STAMPS) | Date

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 NOTE: Riverfront Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.