

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Address		Address	
City State ZIP		City State ZIP	
Main Phone	Alternate Phone	Phone	Fax
Social Security #		Contact Person	
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	DEA #	NPI # License #

Clinical Information			
Chronic Hepatitis C: <input type="checkbox"/> B18.2 Hepatic Encephalopathy: <input type="checkbox"/> K72.90 <input type="checkbox"/> K72.91 Hepatocellular Carcinoma: <input type="checkbox"/> C22.0 <input type="checkbox"/> C22.2 <input type="checkbox"/> C22.7 <input type="checkbox"/> C22.8			
<input type="checkbox"/> Other: _____			
Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 1a (NS5A RAVs: <input type="checkbox"/> No <input type="checkbox"/> Yes) <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		Viral Load	IU/mL Viral Load Date
<input type="checkbox"/> Treatment Naive <input type="checkbox"/> Previously Treated (prior treatment used): _____ <input type="checkbox"/> Non-Responder <input type="checkbox"/> Responder/Relapser			
Duration of Previous Therapy: _____ / _____ / _____ to _____ / _____ / _____ Total of: _____ months			
HIV Coinfected: <input type="checkbox"/> No <input type="checkbox"/> Yes	HBV Coinfected: <input type="checkbox"/> No <input type="checkbox"/> Yes	Solid Organ Transplant Recipient: <input type="checkbox"/> No <input type="checkbox"/> Yes	Awaiting Liver Transplant: <input type="checkbox"/> No <input type="checkbox"/> Yes
Cirrhosis: <input type="checkbox"/> No <input type="checkbox"/> Yes			
If cirrhotic, is patient <input type="checkbox"/> Compensated or <input type="checkbox"/> Decompensated; MUST provide: albumin _____ g/dL, total bilirubin _____ mg/dL, and INR _____			
Drug Allergies	Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs	METAVIR Score	Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Prescription Information			Qty	Refills
<input type="checkbox"/> Doptelet®	20 mg Tablet	<input type="checkbox"/> Take 2 tablets (40 mg total) by mouth once daily for 5 days <input type="checkbox"/> Take 3 tablets (60 mg total) by mouth once daily for 5 days *DOPTELET® should be initiated 10 to 13 days prior to scheduled procedure date	10 15	_____ _____ _____
<input type="checkbox"/> Epclusa®	sofosbuvir and velpatasvir 400 mg/100 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Harvoni®	ledipasvir and sofosbuvir 90 mg/400 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Mavyret®	glecaprevir/pibrentasvir 100 mg/40 mg Tablet	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	28 Day Supply	_____
<input type="checkbox"/> Ribavirin	200 mg <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule	<input type="checkbox"/> 600 mg AM and 600 mg PM (1200 mg) <input type="checkbox"/> 600 mg AM and 400 mg PM (1000 mg) <input type="checkbox"/> 400 mg AM and 400 mg PM (800 mg) <input type="checkbox"/> 400 mg AM and 200 mg PM (600 mg) <input type="checkbox"/> Other: Take _____ mg AM and _____ mg PM	28 Day Supply	_____
<input type="checkbox"/> Sovaldi®	400 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Vosevi™	sofosbuvir, velpatasvir, voxilaprevir 400 mg/100 mg/100 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	28 Day Supply	_____
<input type="checkbox"/> Xifaxan	550 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth twice daily Indicate previously failed therapy: <input type="checkbox"/> Lactulose <input type="checkbox"/> Other _____	30 Day Supply	_____
<input type="checkbox"/> Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, 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.

Prescriber's Signature (no stamps) Substitution Permitted

Date

Prescriber's Signature (no stamps) Dispense As Written

Date