RARE SPECIALTY PHARMACY
@RareSpecialtyRx | RareSpecialtyRx.com | #RareSpecialtyRx

P: (855) 713-7049 | F: (888) 509-1154
398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

IDC-10 Diagnosis Code: ❑B18.2 HCV (Chronic) ❑Other _____ ❑relapsed ❑partial response ❑null response

Previously treated for this condition? ❑Yes ❑No Medication(s) failed: _____

Interferon ❑Yes ❑No # of weeks _____ IU (Date of Labs) _____ ALT_____ AST_____ Hgb_____

HCV Medical Criteria Genotype _____ HCV-Viral Load _____ eGFR _____

HEPATOLOGY ORDER FORM

❑ **EPCLUSA** ❑ 400mg / 100mg tablet (brand) QTY: 28
❑ **SOFOSBUVIR/VELPATASVIR** 400mg / 100mg tablet (generic) Refills: _____
SIG: Take 1 tablet by mouth daily

❑ **HARVONI** ❑ 90mg / 400mg tablet (brand) QTY: 28
❑ **LEDIPASVIR/SOFOSBUVIR** 90mg / 400mg tablet (generic) Refills: _____
SIG: Take 1 tablet by mouth daily

❑ **MAVYRET** ❑ 100mg glecaprevir / 40mg pibrentasvir tablet QTY: 84
Therapy Length: ❑ 8 weeks or ❑ 12 weeks Refills: _____
SIG: Take 3 tablets orally once daily with food

❑ **RIBAVIRIN** Patient Weight (kg) _____ QTY: _____
❑200mg capsule ❑200mg tablet Refills: _____
SIG:

❑ **SOVALDI** ❑ sofosbuvir 400mg tablet QTY: 28
SIG: Take 1 tablet by mouth daily for: Refills: _____
❑12 weeks with Ribavirin and peginterferon (Genotype 1 or 4)
❑12 weeks with Ribavirin (Genotype 2)
❑24 weeks with Ribavirin (Genotype 3)
❑Other:

❑ **VOSEVI** QTY: 28
❑ 400mg sofosbuvir/100mg velpatasvir/100mg voxilaprevir tablet Refills: 2
SIG: Take 1 tablet by mouth daily with food for 12 weeks

❑ **ZEPATIER** ❑ grazoprevir 100mg / elbasvir 50mg tablet QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____

HEPATITIS B ORAL THERAPIES QTY: _____
❑**BARACLUDE** ❑0.5mg ❑1.0mg ❑**HEPSERA** 10mg Refills: _____
❑**EPIVIR** HBV 100mg ❑**VIREAD** 300mg
❑**VEMLIDY** 25mg
SIG:

❑ **NEUPOGEN** ❑300mcg PFS ❑480mcg PFS QTY: _____
❑300mcg VIAL ❑480mcg VIAL Refills: _____
❑ **PROCRIT** ❑10,000IU ❑20,000IU ❑40,000IU
❑ Include 25G 1/2" syringes and alcohol pads with all injectables
SIG:

❑ **XIFAXAN** ❑200mg ❑550mg
❑ 1 200mg TAB PO TID x 3 Days QTY: 9 Refills: _____
❑ 1 550mg TAB PO BID QTY: 60 Refills: _____
❑ 1 550mg TAB PO TID x 14 Days QTY: 42 Refills: _____
❑ **RELISTOR** ❑8mg PFS ❑12mg PFS ❑150mg tablet QTY: ___ Refills: _____
SIG:

❑ **REZDIFFRA** ❑60mg ❑80mg ❑100mg
❑ SIG: <100 kg (actual body weight): 80mg once daily QTY: ___ Refills: _____
❑ SIG: ≥100 kg (actual body weight): 100mg once daily QTY: ___ Refills: _____

❑ **OTHER:** _____
SIG:_____ QTY: ___ Refills: _____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____