



(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.

Hepatitis C Prescription Referral Form

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Pick-up _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis/ICD-10: _____ Genotype: 1a 1b 2 3 4 5 6 Viral Load: _____ Date: _____
 Fibrosis Score: F0 F1 F2 F3 F4 Cirrhosis: None Compensated Decompensated Child-Pugh: A B C
 IL-28: CC CT TT NSSA Polymorphism: Y N NSSA Polymorphism Type: 28 30 31 93 Other _____ HIV Co-infection HBV Co-infection

Prior Therapy	End Date	Treatment Weeks	Response Status			
_____	_____	_____	Naive	Null	Partial	Relapse
_____	_____	_____	Naive	Null	Partial	Relapse
_____	_____	_____	Naive	Null	Partial	Relapse

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Daklinza® (daclatasvir)	60mg 30mg	Take 1 tablet by mouth daily with or without food in combination with sofosbuvir	28 day supply	
Harvoni™ (ledipasvir/sofosbuvir)	90mg/400mg	Take 1 tablet by mouth daily with or without food	28 day supply	
Olysio™	150mg	Take 1 capsule by mouth daily with food (<i>Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi</i>)	28 day supply	2
Pegasys® Prefilled Syringe Vial ProClick®	180mcg 135mcg	180 mcg SQ once weekly 90 mcg SQ once weekly 135 mcg SQ once weekly	28 day supply	
RibaPak® Moderiba®	600mg 800mg 1000mg 1200mg	200 mg Every Morning, 400 mg Every Evening 400 mg Every Morning, 400 mg Every Evening 600 mg Every Morning, 400 mg Every Evening 600 mg Every Morning, 600 mg Every Evening	28 day supply	
RibaSphere® (generic ribavirin)	200mg			
Sovaldi™	400mg	Take 1 tablet by mouth daily with or without food	28 day supply	
Technivie™ (ombitasvir, paritaprevir, and ritonavir tablets)	12.5mg/75mg/50mg	Take 2 ombitasvir, paritaprevir, ritonavir tablets by mouth once daily in the morning with a meal without regard to fat or calorie content (<i>Technivie is FDA approved for use with ribavirin</i>)	28 day supply	
Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets copackaged with dasabuvir tablets)	12.5mg/75mg/50mg/250mg	Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (morning and evening) with a meal without regard to fat or calorie content	28 day supply	
Zepatier™ (elbasvir/grazoprevir)	50mg/100mg	Take 1 tablet by mouth daily with or without food	28 day supply	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____