

MAIN POINT OF CONTACT

Name: _____
Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____ Phone: _____ Phone 2: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____ Secondary Insurance: _____
ID#: _____ RxBin: _____ ID#: _____ RxBin: _____
RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis: _____ ICD10 Code: _____
Secondary Diagnosis: _____ ICD10 Code: _____
Previous Treatment: _____ AST: _____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
<input type="checkbox"/> Harvoni	<input type="checkbox"/> Fixed-dose combination tablet of 90mg of ledipasvir/400mg of sofosbuvir	Take orally once daily with or without food. Do not take within 4 hours of antacids.	28-day supply	
<input type="checkbox"/> Viekira Pak	Ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg and dasabuvir 250mg copackaged	Take two pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and one beige tablet (dasabuvir) twice daily (morning and evening with meals).	28-day supply	<input type="checkbox"/> max 12 wks <input type="checkbox"/> max 24 wks
<input type="checkbox"/> Baraclude	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1 mg			
<input type="checkbox"/> Remicade <input type="checkbox"/> Crohns <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> 100 mg vial	<input type="checkbox"/> Induction: IV at 5mg/kg (Dose = _____ mg) at 0,2,6 weeks <input type="checkbox"/> Maintenance: IV at 5mg/kg (Dose= _____ mg) every 8 weeks <input type="checkbox"/> Other: _____	(# of 100mg vials)	
<input type="checkbox"/> Tysabri				



Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____ NPI#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

***Prescriber Signature:** _____ **Date:** _____

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