HEPATITIS C REFERRAL FORM

1299 McCarter Hwy Newark, NJ 07104
Tel 973-485-8522 Fax: 973-485-8570
Only servicing patients residing in the state of New Jersey

Today's Date _____ Anticipated Start Date _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name _____ Last Name _____ SS# _____ DOB _____ Height _____ 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 ☐ Physician Office ☐ Pharmacy
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

Previously treated ☐ No ☐ Yes, what drugs _____ Interferon ☐ Yes ☐ No # of Weeks _____ ☐ relapsed ☐ partial response ☐ null response
ICD-9 Code ☐ 070.54 HCV (Chronic) Genotype _____ Subtype _____ Liver Biospsy ☐ Yes ☐ No Date _____ Results _____
Other Lab Results ALT _____ Date _____ AST _____ Date _____ Hgb _____ Date _____ HCV RNA _____ Date _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

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	Amount 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	0.4 mL SQ Weekly
☐	112 – 133		80 mcg	0.5 mL SQ Weekly
☐	134 – 144	120 mcg/0.5 mL	96 mcg	0.4 mL SQ Weekly
☐	145 – 166		96 mcg	0.4 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 004-0365-30) Inject SQ weekly
☐ ProClick 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ Pre-Filled Syringe180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly
☐ Other _____
Quantity: ☐ 28 days (4 syringes) Refill x _____

RIBAPAK

Please write DAW in this box ☐ QTY 28 days Refill x ____

	Weight (lbs)	Dosing	
☐	< 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 with Ribavirin (Genotype 2) ☐ 24 weeks with Ribavirin (Genotype 3)

INCIVEK

☐ 750mg (2 x 375mg) QTY 28 days (168 Tabs) Refill x 2
Directions: 3x daily w/food for 12 wks w/peginterferon and ribavirin

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

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

By signing this form and utilizing our services, you are authorizing Giannotto's and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____