Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS

Hepatitis Referral Form

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Patient Soc. Sec#: Date of Birth: / /	Phone: ( ) Fax: ( )
Sex: ❑ Male ❑Female Weight lbs/kg Height	Nurse/Key Office Contact:
Allergies:	

CLINICAL INFORMATION

Diagnosis

❑B18.2 Hepatitis C (Chronic) ❑B18.0 Hepatitis B w/delta agent (Chronic) ❑B18.1 Hepatitis B w/out delta agent (Chronic)

❑Other ICD-10 _____ Co-infected with: ❑HIV ❑N/A

HCV Genotype:_____ HCV Pre-treatment Viral Load:_____ Collection Date:_____

HEPATITIS C PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
❑ **Epclusa®** **(sofosbuvir/velpatasvir)**	❑ 400mg/100mg tablet	❑ Take one tablet by mouth once daily. **Duration:** ❑ 12 weeks ❑ Other_____	❑ 28 tablets	
❑ **Harvoni®** **(ledipasvir/sofosbuvir)**	❑ 90mg/400mg tablet	❑ Take one tablet by mouth once daily. ❑ Other:_____ **Duration:** ❑ 8 weeks ❑12 weeks ❑ 24 weeks ❑ _____	❑ 28 tablets	
❑ **Mavyret™** (glecaprevir/pibrentasvir)	❑ 100mg/40mg tablet	❑ Take **3** tablets by mouth once daily with food. **Duration:** ❑ 8 weeks ❑12 weeks ❑ 16 weeks	❑ 84 tablets	
❑ **Sovaldi®** **(sofosbuvir)**	❑ 400mg tablet	❑ Take one tablet by mouth once daily. ❑ Other:_____ **Duration:** ❑ 12 weeks ❑24 weeks ❑_____	❑ 28 tablets	
❑ **Vosevi™** **(sofosbuvir/velpatasvir/voxilaprevir)**	❑ 400mg/100mg/100mg tablet	❑ Take one tablet by mouth once daily with food. **Duration:** ❑ 12 weeks	❑ 28 tablets	
❑ **Zepatier™** **(elbasvir/grazoprevir)**	❑ 50mg /100mg tablet	❑ Take one tablet by mouth once daily. ❑ Other:_____ **Duration:** ❑ 12 weeks ❑16 weeks ❑Other_____	❑ 28 tablets	
❑ **Ribavirin**	❑ 200mg tablet ❑ 200mg capsule	❑ Take _____ tabs/caps QAM & _____tabs/caps QPM with food. ❑ Other:_____	Qty:_____	
❑ **Other** _____	❑ _____	❑ _____	❑ _____	

HEPATITIS B PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
❑ **Adefovir dipivoxil**	❑ 10mg tablet	❑ Take one tablet by mouth once daily.	❑ 30 tablets	
❑ **Baraclude®** **(entecavir)**	❑ 0.5mg tablet ❑ 1mg tablet	❑ Take one tablet by mouth once daily on an empty stomach.	❑ 30 tablets	
❑ **Epivir-HBV®** **(lamivudine)**	❑ 100mg tablet	❑ Take one tablet by mouth once daily.	❑ 30 tablets	
❑ **Vemlidy®** (tenofovir alafenamide)	❑ 25mg tablet	❑ Take one tablet by mouth once daily with food.	❑ 30 tablets	
❑ **Viread®** (tenofovir disoproxil fumarate)	❑ 300mg tablet	❑ Take one tablet by mouth once daily.	❑ 30 tablets	
❑ **Other** _____	❑ _____	❑ _____	❑ _____	

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities. You are certifying that the above therapy is medically necessary, and that all the above information is accurate to the best of your knowledge.*

Date: _____ _____ _____

DISPENSE AS WRITTEN **MAY SUBSTITUTE**