VERBAL ORDER FORM
INFECTIOUS DISEASE

QuickRX SPECIALTY PHARMACY

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Ph 347-691-3494 | Fax 347-691-3496
NPI# 1003148321 NCPDP# 3364471
info@QuickRxSpecialty.com

Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRX Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ **B20** HIV/AIDS ☐ **R64** Cachexia (HIV Wasting) ☐ **B18.2** Hepatitis C (chronic)
☐ **B18.1** Hepatitis B ☐ HIV-Infected patients with abdominal lipodystrophy ☐ Other _____
CD4 count_____ Viral Load/HIV RNA_____ Hgb/Hct_____ WBC/ANC_____ CrCl_____ (Please include copy of most recent labs)
Has patient been on therapy and relapsed? ☐ Yes ☐ No List of medication(s) _____
Is patient currently on therapy? ☐ Yes ☐ No List of medication(s) _____
Will patient stop taking the medication(s) before or when starting the new medication? ☐ Yes ☐ No
List of medication(s) to be discontinued (Note: Fuzeon® must be taken as part of a combination antiviral regimen)_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE/NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS

DESCOVY® ☐ 200mg/25mg
EMTRIVA® ☐ 200mg ☐ 10mg/mL Sol
EPIVIR® ☐ 150mg ☐ 300mg ☐ 10mg/mL Sol
RETROVIR® ☐ 100mg tab ☐ 300mg tab ☐ 10mg/mL Syrup
VIDEX® EC ☐ 125mg ☐ 200mg ☐ 250mg ☐ 400mg
Plain Videx Solution ☐ 4 gram ☐ 2 gram
VIREAD® ☐ 300mg
ZERIT® ☐ 15mg ☐ 20mg ☐ 30mg ☐ 40mg ☐ 1mg/mL Sol
ZIAGEN® ☐ 300mg ☐ 20mg/mL Sol
SIG:_____ QTY:_____ Refill: _____

COMBINATION ANTIRETROVIRALS

ATRIPLA® ☐ 600/200/300mg
BIKTARVY® ☐ 50/200/25mg
COMBIVIR® ☐ 150/300mg
COMPLERA® ☐ 200/25/300mg
DELSTRIGO™ ☐ 100/300/300mg
DOVATO™ ☐ 50/300mg
EPZICOM® ☐ 600/300mg
GENVOYA® ☐ 150/150/200/10mg
JULUCA® ☐ 50/25mg
ODEFSEY® ☐ 200/25/25mg
STRIBILD® ☐ 150/150/200/300mg
SYMTUZA™ ☐ 800/150/200/10mg
TRIUMEQ® ☐ 600/50/300mg
TRIZIVIR® ☐ 300/150/300mg
TRUVADA® ☐ 200/300mg
SIG:_____ QTY:_____ Refill: _____

NON-NUCLEOSIDE ANALOGS

EDURANT® ☐ 25mg
INTELENCE™ ☐ 100mg ☐ 200mg ☐ 25mg
PIFELTRO™ ☐ 100mg
RESCRIPTOR® ☐ 100mg ☐ 200mg
SUSTIVA® ☐ 50mg cap ☐ 200mg cap ☐ 600mg tab
VIRAMUNE® ☐ 200mg ☐ XR 100mg ☐ XR 400mg
SIG:_____ QTY:_____ Refill: _____

INTEGRASE INHIBITORS

ISENTRESS® ☐ 400mg ☐ 600mg
TIVICAY® ☐ 50mg
VITEKTA® ☐ 85mg ☐ 150mg
SIG:_____ QTY:_____ Refill: _____

PROTEASE INHIBITORS

APTIVUS® ☐ 250mg ☐ 100mg/mL Sol
CRIXIVAN® ☐ 200mg ☐ 400mg
EVOTAZ™ ☐ 300mg/150mg
INVIRASE® ☐ 200mg ☐ 500mg
KALETRA® ☐ 100mg/25mg tab ☐ 200mg/50mg tab ☐ 80mg/20mg/mL Sol
LEXIVA® ☐ 700mg ☐ 50mg/ml Susp
NORVIR® ☐ 100mg Tab ☐ 80mg/mL ☐ 100mg Cap
PREZCOBIX™ ☐ 800mg/150mg
PREZISTA® ☐ 75mg ☐ 150mg ☐ 600mg ☐ 800mg ☐ 100mg/mL Susp
REYATAZ® ☐ 150mg ☐ 200mg ☐ 300mg
VIRACEPT® ☐ 250mg ☐ 625mg
SIG:_____ QTY:_____ Refill: _____

FUSION INHIBITORS

FUZEON® ☐ 90mg QTY:_____ Refill: _____

PRE-EXPOSURE PROPHYLAXIS (for HIV PrEP)

TRUVADA® ☐ 200/300mg tablet
SIG: Take 1 tablet by mouth daily QTY:_____ Refill:_____
DESCOVY® ☐ 200/25mg tablet
SIG: Take 1 tablet by mouth daily QTY:_____ Refill:_____

POST-EXPOSURE PROPHYLAXIS (for HIV PEP)

TRUVADA® ☐ 200/300mg QTY: 28 Refills: 0
SIG: Take one tablet by mouth daily for four weeks
ISENTRESS® ☐ 400mg QTY: 56 Refills: 0
SIG: Take one tablet by mouth twice daily for four weeks

XERAVA® ☐ 50mg vial
SIG: Infuse _____ (1mg/kg dose) IV every 12 hours for _____days (4-14 days) QTY:____vials Refill: _____

SIVEXTRO® ☐ 200mg tablet QTY: 6 Refill: _____
SIG: Take one tablet by mouth daily for 6 days
BAXDELA™ ☐ 450mg tablet QTY: _____ Refill: _____
SIG: Take one tablet by mouth twice daily for ____ days

☐ **BACTRIM®** ☐ **DIFLUCAN®** ☐ **SELZENTRY®**
☐ **MEGACE®** 40mg/mL ☐ **MEGACE® ES** 625mg/5ml
SIG:_____ QTY:_____ Refill: _____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

☐ **HARVONI®** ledipasvir 90mg/sofosbuvir 400mg
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **EPCLUSA®** sofosbuvir 400mg/velpatasvir 100mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **ZEPATIER™** grazoprevir 100mg/elbasvir 50mg tablet
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **MAVYRET™** 100mg glecaprevir/40mg pibrentasvir tablet
Therapy Length: ☐ 8 weeks or ☐ 12 weeks
SIG: Take 3 tablets by mouth once daily with food
QTY: 84 Refill: _____

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

☐ **SOVALDI®** 400mg tablet QTY: 28 Refill: _____
SIG: 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)
☐ Other: _____

RIBAVIRIN® ☐ 200mg cap ☐ 200mg tab Weight: _____kg
QTY:_____ Refill: _____ SIG:_____

HEPATITIS B ORAL THERAPIES

BARACLUDE® ☐ 0.5mg ☐ 1.0mg ☐ **EPIVIR® HBV** 100mg
☐ **HEPSERA®** 10mg ☐ **VEMLIDY®** 25mg ☐ **VIREAD®** 300mg
QTY:_____ Refill: _____ SIG:_____

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

XIFAXAN® ☐ 200mg ☐ 550mg
☐ 1 200mg tab PO TID x 3 Days QTY: 9 Refill: _____
☐ 1 550mg tab PO BID QTY: 60 Refill: _____
☐ 1 550mg tab PO TID x 14 Days QTY: 42 Refill: _____
RELISTOR® ☐ 8mg PFS ☐ 12mg PFS ☐ 150mg tablet
QTY:_____ Refill: _____ SIG:_____

OTHER MEDICATION_____
SIG:_____ **QTY:**____ **REFILL:**____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

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

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

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.