VERBAL ORDER FORM
GASTROENTEROLOGY

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 ☐ **K50.00** Crohn's Disease ☐ **B18.2** Chronic Hep C ☐ **K58.0** IBS-D ☐ **K51.90** Ulcerative Colitis ☐ Other_____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
PPD (TB Test) ☐ Yes ☐ No Date_____ Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **HUMIRA® PEN Crohn's Disease Starter Package** ☐ **HUMIRA® Citrate-Free PEN Crohn's Disease Starter Package**
☐ Starter Dose: Inject 160 mg SQ on Day 1, then inject 80mg SQ on Day 15 QTY: 4 week supply Refill: _____
☐ Alt. Dosage _____ QTY: _____ Refill: _____

HUMIRA® MAINTENANCE THERAPY
☐ **HUMIRA® PEN** 40 mg/0.8 mL ☐ **HUMIRA® PFS** 40 mg/0.8 mL ☐ **HUMIRA® Citrate-Free PEN** 40 mg/0.4 mL ☐ **HUMIRA® Citrate-Free PFS** 40 mg/0.4 mL
☐ Maintenance SIG: Inject 40 mg SQ every other week starting on Day 29 QTY: 2 Refill: _____
☐ Alt. Dosage _____ QTY: 28 days supply Refill: _____

SIMPONI™ ☐ **SMARTJECT™ AUTOINJECTOR** 50mg/0.5mL ☐ **PFS** 50mg/0.5mL ☐ **SMARTJECT™ AUTOINJECTOR** 100mg/1mL ☐ **PFS** 100mg/mL
☐ Starter SIG: 200mg SQ at week 0, then 100mg SC at week 2 QTY: 3 Refill: 0
☐ Maintenance SIG: 100mg SQ every 4 weeks | QTY: 1 ☐ 50mg SQ every 4 weeks | QTY: 1 Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

STELARA® ☐ 130 mg/26 mL vial ☐ 45mg SD Vial Patient Weight (kg): _____
☐ 45mg PFS ☐
☐ Starter SIG: Infuse _____ mg IV initially at week 0. QTY: ____vials Refill: 0
☐ Maintenance SIG: Inject 90mg SQ 8 weeks after the initial IV dose, then every 8 weeks. QTY: _____ Refill: _____

Weight of Patient (Kg)	Recommended Dosage	Vials
≤ 55 kg or less	260 mg	2
55 kg to 85 kg	390 mg	3
≥ 85 kg	520 mg	4

XELJANZ® ☐ 5mg tablet ☐ 10mg tablet
☐ SIG: Take one 5mg tablet by mouth twice daily QTY: 60 Refill: _____
☐ SIG: Take one 10mg tablet by mouth twice daily QTY: 60 Refill: _____

CIMZIA® ☐ 200mg/1ml PFS ☐ PFS Starter Kit
☐ Starter SIG: Inject 400mg SQ on day 1, at week 2 & at week 4
☐ Maintenance SIG: Inject 400mg SQ every 4 weeks QTY: 4 wk supply Refill: _____

☐ **DIFICID®** 200mg tablet QTY: 20 Refill: _____
SIG: Take one tablet orally twice daily for 10 days with or without food

☐ **ENTYVIO®** 300mg
☐ Starter SIG: Infuse 300mg IV at weeks 0, 2, & 6, then maintenance QTY: 3 Refill: _____
☐ Maintenance SIG: Infuse 300mg IV every 8 weeks QTY: 1 Refill: _____

VIBERZI® ☐ 100mg ☐ 75mg
SIG: Take 1 tablet by mouth twice daily with food QTY: 60 Refill: _____

☐ **DONNATAL®** 16.2mg tablet
☐ **ZOFRAN®** ☐ 4mg ☐ 8mg
☐ **RELISTOR®** ☐ 8mg PFS ☐ 12mg PFS ☐ 150mg tablet
☐ **PROCRIT®** vial includes 25G 1/2" syringes and alcohol pads w/ all dispenses
☐ **XIFAXAN®** ☐ 200mg ☐ 550mg
☐ 1 200mg tablet PO TID x 3 Days QTY: 9 Refill: _____
☐ 1 550mg tablet PO BID QTY: 60 Refill: _____
☐ 1 550mg tablet PO TID x 14 Days QTY: 42 Refill: _____
SIG: _____ QTY: _____ Refill: _____

☐ **EPCLUSA®** 400mg/100mg tablet (brand) ☐ DAW
☐ **SOFOSBUVIR/VELPATASVIR** 400mg/100mg tablet (generic)
SIG: Take 1 tablet by mouth daily QTY: 28 Refill: _____

☐ **HARVONI®** 90mg/400mg tablet (brand) ☐ DAW
☐ **LEDIPASVIR/SOFOSBUVIR** 90mg/400mg tablet (generic)
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 orally once daily with food QTY: 84 Refill: _____

RIBAVIRIN® ☐ 200mg capsules ☐ 200mg tablets
SIG: ☐ <75kg: 400mg in the AM and 600mg in the PM QTY: _____ Refill: _____
☐ >75kg: 600mg in the AM and 600mg in the PM QTY: _____ Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

☐ **SOVALDI®** sofosbuvir 400mg tablet QTY: 28 Refill: _____
SIG: Take 1 tablet by mouth daily for:
☐ 12 weeks with Ribavirin and peginterferon (*Genotype 1 or 4*)
☐ 12 weeks with Ribavirin (*Genotype 2*)
☐ 24 weeks with Ribavirin (*Genotype 3*)
☐ Other: _____

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

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

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

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

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

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.