Orsini
Rare Disease Pharmacy Solutions

Fax: 877-860-2504 **Phone:** 847-457-4259

HEPCLUDEX INJECTION ORDER

(bulevirtide-gmod)

1 PATIENT INFORMATION

Patient Name: _____

Primary Phone: _____ DOB: _____

Address: _____

City, State, Zip: _____

Allergy: _____

Gender: ○ Male ○ Female

ICD-10 Code: ☐ B18.0 ☐ Other _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____

State License #: _____ NPI#: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

HCP Office Email: _____

3 PRESCRIPTION INFORMATION

MEDICATION

☒ HEPCLUDEX: supplied as a single-dose vial of lyophilized powder for subcutaneous injection after reconstitution (after reconstitution with 1mL of Sterile Water for Injection, each vial delivers 8.5mg of bulevirtide-gmod)

ROUTE	DIRECTIONS	QUANTITY	REFILLS
☒ Subcutaneous (SC)	☒ Inject 8.5mg HEPCLUDEX subcutaneously once daily	30 Day Supply	_____
Supplies	☒ I authorize ancillary supplies such as alcohol wipes, sterile syringes, sterile transfer needles, sterile injection needles, cotton balls and/or gauze, adhesive bandages, a sharps container and Sterile Water for Injection as needed to prepare and administer the therapy.		

4 PROVIDER SIGNATURE

X _____ _____

PRODUCT SUBSTITUTION PERMITTED SIGNATURE — Date of Signature

X _____ _____

DISPENSE AS WRITTEN SIGNATURE — Date of Signature

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