

Prescription & Enrollment Form Hepatitis



(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name		First Name	
Social Security #		Date of Birth	
Parent or Guardian			
Home Phone		Other Contact Phone	
Home Address			
City, State, Zip			

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

<input type="checkbox"/> 070.54 Hepatitis C	<input type="checkbox"/> 070.32 Hepatitis B	<input type="checkbox"/> Other ICD 9 _____	<input type="checkbox"/> HIV Co-infection
Patient Weight	lb/kg	Patient Height	
Liver Biopsy Done: <input type="checkbox"/> yes <input type="checkbox"/> no	Date	Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> unknown	
Pre-Treatment ALT	Date	Viral Load:	
Most Recent ALT	Date	Allergies:	
<input type="checkbox"/> Previously Treated w/ Interferon	Date		

PRESCRIPTION INFORMATION

<input type="checkbox"/> INFERGEN® <input type="checkbox"/> 9mcg/0.3ml Vial <input type="checkbox"/> 15mcg/0.5ml Vial	Directions: <input type="checkbox"/> 9mcg SQ 3 times per week <input type="checkbox"/> 15mcg SQ 3 times per week <input type="checkbox"/> Other (please specify):	Qty:
		Refills:
<input type="checkbox"/> PEGASYS® <input type="checkbox"/> 180mcg/0.5ml Prefilled Syringe <input type="checkbox"/> 180mcg/1ml Vial	Directions: <input type="checkbox"/> 180mcg SQ weekly <input type="checkbox"/> Other (please specify):	Qty:
		Refills:
<input type="checkbox"/> PEG-INTRON® <input type="checkbox"/> 50mcg/0.5ml Vial <input type="checkbox"/> 50mcg/0.5ml Redipen <input type="checkbox"/> 80mcg/0.5ml Vial <input type="checkbox"/> 80mcg/0.5ml Redipen <input type="checkbox"/> 120mcg/0.5ml Vial <input type="checkbox"/> 120mcg/0.5ml Redipen <input type="checkbox"/> 150mcg/0.5ml Vial <input type="checkbox"/> 150mcg/0.5ml Redipen	Directions: <input type="checkbox"/> 0.4ml SQ weekly <input type="checkbox"/> 0.5ml SQ weekly <input type="checkbox"/> Other (please specify):	Qty:
		Refills:
<input type="checkbox"/> RIBAVIRIN® 200mg	Directions: _____ morning _____ evening	Qty:
		Refills:

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

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SUPPLIES NEEDED (if medication is to be administered in the patient's home):

If checked, please specify the size and type (if applicable):

- Syringes/Needles Swabs Sharps Container Other

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other	Date Medication Needed:
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Physician's Name (Please Print) _____

Physician's Address _____

Phone _____ Fax _____

Dr.'s Office Contact Name _____

Physician's Signature _____ Date _____

Physician's DEA# _____

License # _____ NPI _____

Fax completed form to Medex BioCare (866) 755-6339