

# HEPATITIS C REFERRAL FORM

**SIGN AND FAX THIS FORM TO 877.828.3939**  
**If you have questions, please call 877.627.MEDS (6337)**

|                           |                            |        |                               |                  |
|---------------------------|----------------------------|--------|-------------------------------|------------------|
| <b>PATIENT/PREScriBER</b> | <b>PATIENT INFORMATION</b> |        | <b>PREScriBER INFORMATION</b> |                  |
|                           | First name:                | MI:    | Title:                        | First name:      |
|                           | Last name:                 |        | Last name:                    | State license #: |
|                           | Patient DOB:               | Sex:   | Provider NPI #:               | DEA #:           |
|                           | Address:                   |        | Office name:                  | Office contact:  |
|                           | City/State/Zip:            |        | Address:                      |                  |
|                           | Primary phone:             |        | City/State/Zip:               |                  |
| Alternate phone:          |                            | Phone: | Fax:                          |                  |

|             |  |                   |          |      |
|-------------|--|-------------------|----------|------|
| <b>PLAN</b> | <b>FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS</b> |                   |          |      |
|             | Primary insurance:   | Policy ID #:      | Group #: |      |
|             | Policyholder name:   | Policyholder DOB: | PCN:     | BIN: |

|  |   |                      |         |
|--|---|----------------------|---------|
| <b>CLINICAL</b>  | Primary diagnosis/ICD 9:  | Height:              | Weight: |
|  | Genotype:   | Allergies:           |         |
|  | Initial viral load: _____ IU/ml Date:   | Current medications: |         |
|  | Previously treated: <input type="checkbox"/> Yes <input type="checkbox"/> No Previous treatment used: |                      |         |
| Previous treatment response: <input type="checkbox"/> Partial responder <input type="checkbox"/> Relapser <input type="checkbox"/> Cirrhosis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated |   |                      |         |

|  |                   |  |  |   |   |
|--|-------------------|--|--|---|---|
| <b>PRESCRIPTION INFORMATION</b>  | Date needed:      | <input type="checkbox"/> New prescription  | <input type="checkbox"/> Refill prescription   | <input type="checkbox"/> New to therapy | <input type="checkbox"/> Restarting therapy |
|  | Deliver to:       | <input type="checkbox"/> Patient's home  | <input type="checkbox"/> Prescriber's facility | <input type="checkbox"/> Other: _____   |   |
|  | <b>MEDICATION</b> | <b>FORM AND STRENGTH</b>   |  | <b>QTY</b>                              | <b>DOSE, DIRECTIONS AND FREQUENCY</b>       |
|  | <b>Pegasys</b>    | <input type="checkbox"/> 180 mcg syringe 4 pack <input type="checkbox"/> 135 mcg ProClick 4 pack<br><input type="checkbox"/> 180 mcg vial <input type="checkbox"/> 180 mcg ProClick 4 pack                       |  |   |   |
|  | <b>PegIntron</b>  | <input type="checkbox"/> 50 mcg<br><input type="checkbox"/> 80 mcg <input type="checkbox"/> Vial<br><input type="checkbox"/> 120 mcg <input type="checkbox"/> 4 pack Redipen<br><input type="checkbox"/> 150 mcg |  |   |   |
|  | <b>RibaPack</b>   | <input type="checkbox"/> 1,200 mg/day (600 mg AM/600mg PM)<br><input type="checkbox"/> 1,000 mg/day (600 mg AM/400mg PM)<br><input type="checkbox"/> 800 mg/day (400 mg AM/400mg PM)                             |  |   |   |
|  | <b>Ribavirin</b>  | <input type="checkbox"/> 200 mg <input type="checkbox"/> Tablets <input type="checkbox"/> Capsules<br><input type="checkbox"/> 400 mg tablet <input type="checkbox"/> 600 mg tablet                              |  |   |   |
|  | <b>Infergen</b>   | <input type="checkbox"/> 9 mcg/0.3 ml <input type="checkbox"/> 15 mcg/0.5 ml   |  |   |   |
|  | <b>VICTRELIS</b>  | <input type="checkbox"/> 200 mg capsules   |  |   |   |
|  | <b>INCIVEK</b>    | <input type="checkbox"/> 375 mg tablets  |  |   |   |
| <input type="checkbox"/> Procrit <input type="checkbox"/> Neulasta<br><input type="checkbox"/> Aranesp <input type="checkbox"/> Neupogen |                   |  |  |   |   |
| Other <input type="checkbox"/>   |                   |  |  |   |   |
| <input type="checkbox"/> Check here if you would like associated supplies dispensed along with injectable medications.                   |                   |  |  | <b>REFILLS: NR 1 2 3 4 5</b> _____      |   |
| State restrictions apply. Separate prescriptions are required in some jurisdictions.   |                   |  |  |   |   |

**PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.**

**Dispense as written/Do not substitute** \_\_\_\_\_ **Date**  **Substitution permitted/Brand exchange permitted** \_\_\_\_\_ **Date**

For states requiring hand written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

CONFIDENTIALITY NOTICE: This fax is for use only by the person named above. It is private. It may be subject to HIPAA Privacy and Security rules. You may not use, copy or share this fax without permission. Please call us at 800.858.0723 if you received this fax by mistake. Do not destroy this fax until you have spoken with us. We may ask you to destroy or return the fax to us. Thank you for your cooperation.

BLUE CROSS® and BLUE SHIELD® and the Cross and Shield symbols are registered marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. © Live Smart. Live Healthy. is a registered mark of the Blue Cross and Blue Shield of Montana, an independent licensee of the Blue Cross and Blue Shield Association.

4951-F M T © Prime Therapeutics LLC 04/12 Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy) is a wholly owned subsidiary of Prime Therapeutics LLC.