Blue Cross Blue Shield of Montana
Live Smart. Live Healthy.®

PRIME THERAPEUTICS
SPECIALTY PHARMACY™

HEPATITIS C REFERRAL FORM

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

PATIENT/PRESCRIBER

PATIENT INFORMATION		PRESCRIBER INFORMATION	
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:

PLAN

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS

Primary insurance:	Policy ID #:		Group #:
Policyholder name:	Policyholder DOB:	PCN:	BIN:

CLINICAL

Primary diagnosis/ICD 9:	Height:	Weight:
Genotype:	Allergies:	
Initial viral load: _____IU/ml Date:	Current medications:	
Previously treated: ☐ Yes ☐ No Previous treatment used:		
Previous treatment response: ☐ Partial responder ☐ Relapser	Cirrhosis: ☐ Yes ☐ No	☐ Compensated ☐ Decompensated

PRESCRIPTION INFORMATION

Date needed: ☐ New prescription ☐ Refill prescription ☐ New to therapy ☐ Restarting therapy

Deliver to: ☐ Patient's home ☐ Prescriber's facility ☐ Other:_____

MEDICATION	FORM AND STRENGTH	QTY	DOSE, DIRECTIONS AND FREQUENCY
Pegasys	☐ 180 mcg syringe 4 pack ☐ 135 mcg ProClick 4 pack ☐ 180 mcg vial ☐ 180 mcg ProClick 4 pack		
PegIntron	☐ 50 mcg ☐ 80 mcg ☐ Vial ☐ 120 mcg ☐ 4 pack Redipen ☐ 150 mcg		
RibaPack	☐ 1,200 mg/day (600 mg AM/600mg PM) ☐ 1,000 mg/day (600 mg AM/400mg PM) ☐ 800 mg/day (400 mg AM/400mg PM)		
Ribavirin	☐ 200 mg ☐ Tablets ☐ Capsules ☐ 400 mg tablet ☐ 600 mg tablet		
Infergen	☐ 9 mcg/0.3 ml ☐ 15 mcg/0.5 ml		
VICTRELIS	☐ 200 mg capsules		
INCIVEK	☐ 375 mg tablets		
☐ **Procrit** ☐ **Neulasta** ☐ **Aranesp** ☐ **Neupogen**			
Other ☐			

☐ Check here if you would like associated supplies dispensed along with injectable medications. **REFILLS: NR 1 2 3 4 5**____
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.).