PharmaCare Specialty Pharmacy
HEPATITIS C & HEPATITIS B Referral Form

FAX REFERRAL TO: 800-447-3694
Phone: 800-990-9247

Date: _________ **Needs by Date:** ___________ **●Ship to** ☐ **Patient** ☐ **Office** ☐ **Training at PharmaCare**

PATIENT INFORMATION
(Complete the following ***or send patient demographic sheet***)

Patient Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Alternate Phone: ______________________
Patient SS#: ______________________
Date of Birth: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
State License #: _________ DEA #: ___________
Group or Hospital: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________________
Fax: ______________________
Contact Person: ______________________

INSURANCE INFORMATION

Primary Insurance/ Prescription Card: PLEASE FAX COPY OF INS CARD (FRONT & BACK)

Secondary Insurance/ Prescription Card: PLEASE FAX COPY OF INS CARD (FRONT & BACK)

CLINICAL INFORMATION
*(**OPTIONAL** – but will assist in insurance authorization and patient education)*

Diagnosis: ☐ 070.54 - Hepatitis C (chronic) ☐ 070.32 – Hepatitis B (chronic) Weight: ______________________

HCV/HBV Viral Load: ________________ IU/ml (HCV) ________________ cop/ml (HBV) Previously Treated? ________

HCV Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Pre-Treatment ALT: ______

Liver Biopsy completed? ☐ Yes ☐ No Results: _________________________ Length of Treatment: _____________

PRESCRIPTION INFORMATION

PEG INTRON®:

☐ REDIPEN ☐ VIAL *(Injection supplies included)*

	Weight (lbs)	Strength (Dose)	Directions *(1.5ug/kg/wk)*
☐	<88lbs	50/0.5 (50ug)	Inject 0.5ml SC Qweek
☐	89-110lbs	80/0.4 (64ug)	Inject 0.4ml SC Qweek
☐	111-132lbs	80/0.5 (80ug)	Inject 0.5ml SC Qweek
☐	133-165lbs	120/0.4 (96ug)	Inject 0.4ml SC Qweek
☐	166-187lbs	120/0.5 (120ug)	Inject 0.5ml SC Qweek
☐	>187lbs	150/0.5 (150ug)	Inject 0.5ml SC Qweek
☐	Other:	______________________	

Quantity: ______ Refills: _____

PEGASYS®:

☐ PREFILLED SYRINGE Convenience Pack - 180ug/0.5ml
(Directions: Inject 180ug SC Qweek as directed)

☐ VIAL – 180ug/1ml *(include 25G1/2" syringes/alcohol pads)*
(Directions: Inject 180ug SC Qweek as directed)

☐ Other: ______________________

Quantity: 4 Weeks Supply Refills: _____

INFERGEN®:

☐ 15ug SC QD ☐ 15ug SC TIW ☐ 9ug SC QD

☐ 15ug SC QD x 12 weeks, then 15ug SC TIW x 36 weeks

Quantity: 4 Weeks Supply Refills: _____
(Include 25G1/2" syringes and alcohol pads with all dispenses)

RIBAVIRIN:

RIBA-PAK® (generic ribavirin) **TABLET DOSE PACK**

☐ 600-600 *(600mg tab qam,600mg tab qpm – 1200/day)*
☐ 600-400 *(600mg tab qam,400mg tab qpm – 1000/day)*
☐ 400-400 *(400mg tab qam,400mg tab qpm – 800/day)*

Quantity: 4 Weeks Supply Refills: _____

Other Ribavirin

☐ Ribavirin 200mg Capsules ☐ Rebetol® 40mg/ml Sol.
☐ Ribavirin 200mg Tablets ☐ Other: ____________

Directions: ___ capsules/tabs qam, ___ capsules/tabs qpm

Quantity: 30 Day Supply Refills: _____

HEPATITIS B ORAL THERAPIES:

☐ Baraclude® 0.5mg ☐ Baraclude® 1mg
☐ Hepsera® 10mg ☐ Epivir HBV® 100mg

Directions: 1 tablet po QD Alternate Dir: _______________

Quantity: 30 Day Supply Refills: _____

CHEMOTHERAPY-INDUCED ANEMIA/NEUTROPENIA:

☐ Procrit® Vial ☐ Neupogen® Prefilled Syringe
☐ Epogen® Vial ☐ Neulasta® Prefilled Syringe
☐ Aranesp® Prefilled Syringe

Include 25G1/2" syringes w/ vials

Directions: __________________________

Strength: __________ Quantity: 4 Weeks Supply Refills: _____

☐ *Do Not Substitute*

____
PRESCRIBER SIGNATURE

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.*

Revised DP 4/10/06
Gen Hep