



# Hepatitis Order Form

2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232  
 Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040  
 www.transcriptpharmacy.com

## Patient Information

Patient name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Cell \_\_\_\_\_  
 DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Drug allergies \_\_\_\_\_  Male  Female

## Prescriber Information

Prescriber name \_\_\_\_\_ Lic# \_\_\_\_\_  
 DEA# \_\_\_\_\_ Tax ID \_\_\_\_\_  
 Practice name \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

## Insurance, Medicare or Medicaid Information

Primary Insurance \_\_\_\_\_ Secondary Insurance (*If applicable*) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
 Insurance phone \_\_\_\_\_ Insurance phone \_\_\_\_\_  
 Prescription Drug Coverage: Company \_\_\_\_\_ Phone \_\_\_\_\_  
 RXGRP# \_\_\_\_\_ RXBIN# \_\_\_\_\_ PCN/ID# (if avail.) \_\_\_\_\_

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

## Clinical Information

Diagnosis:  070.54 Chronic Hepatitis C  070.32 Hepatitis B Genotype \_\_\_\_\_ Diagnosis date: \_\_\_\_/\_\_\_\_/\_\_\_\_ HIV Co-infection?  Yes  No  
 HCV/HBV viral load \_\_\_\_\_ copies/ml ALT \_\_\_\_\_ Liver biopsy results (if applicable) \_\_\_\_\_  
 Previously treated for HCV?  Yes  No If yes, was patient a:  Non-responder [OR]  Responder/Relapser Previous treatment: \_\_\_\_\_  
 Treatment duration: \_\_\_\_\_ weeks Other medication patient is currently taking including OTC medications (or fax medication profile): \_\_\_\_\_

Drug name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills																																				
<input type="radio"/> Pegasys® 180mcg/0.5ml Prefilled Syringe	Inject: <input type="radio"/> 180mcg SC QW <input type="radio"/> 135mcg SC QW <input type="radio"/> 90mcg SC QW <input type="radio"/> Other _____	28 day supply	Refills																																				
<input type="radio"/> Peg-Intron® Redipen	<table border="1"> <thead> <tr> <th>Patient Wt.</th> <th>Strength/Dose</th> <th>Ribavirin</th> <th>Patient Wt.</th> <th>Strength/Dose</th> <th>Ribavirin</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/> &lt;87lbs</td> <td>50mcg / 0.5ml SC QW</td> <td>800mg/day</td> <td><input type="radio"/> 167-177lbs</td> <td>120mcg / 0.5ml SC QW</td> <td>1000mg / day</td> </tr> <tr> <td><input type="radio"/> 87 -111lbs</td> <td>80mcg / 0.4ml SC QW</td> <td>800mg/day</td> <td><input type="radio"/> 178-187lbs</td> <td>120mcg / 0.5ml SC QW</td> <td>1200mg / day</td> </tr> <tr> <td><input type="radio"/> 112-133lbs</td> <td>80mcg / 0.5ml SC QW</td> <td>800mg/day</td> <td><input type="radio"/> 189-231lbs</td> <td>150mcg / 0.5ml SC QW</td> <td>1200mg / day</td> </tr> <tr> <td><input type="radio"/> 134-144lbs</td> <td>120mcg / 0.4ml SC QW</td> <td>800mg/day</td> <td><input type="radio"/> &gt;231lbs</td> <td>150mcg / 0.5ml SC QW</td> <td>1400mg / day</td> </tr> <tr> <td><input type="radio"/> 145-166lbs</td> <td>120mcg / 0.4ml SC QW</td> <td>1000mg / day</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Patient Wt.	Strength/Dose	Ribavirin	Patient Wt.	Strength/Dose	Ribavirin	<input type="radio"/> <87lbs	50mcg / 0.5ml SC QW	800mg/day	<input type="radio"/> 167-177lbs	120mcg / 0.5ml SC QW	1000mg / day	<input type="radio"/> 87 -111lbs	80mcg / 0.4ml SC QW	800mg/day	<input type="radio"/> 178-187lbs	120mcg / 0.5ml SC QW	1200mg / day	<input type="radio"/> 112-133lbs	80mcg / 0.5ml SC QW	800mg/day	<input type="radio"/> 189-231lbs	150mcg / 0.5ml SC QW	1200mg / day	<input type="radio"/> 134-144lbs	120mcg / 0.4ml SC QW	800mg/day	<input type="radio"/> >231lbs	150mcg / 0.5ml SC QW	1400mg / day	<input type="radio"/> 145-166lbs	120mcg / 0.4ml SC QW	1000mg / day				28 day supply	Refills
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<input type="radio"/> Infergen®	Inject: <input type="radio"/> 15ug SC QD <input type="radio"/> 9ug SC QD <input type="radio"/> Other _____	28 day supply	Refills																																				
<input type="radio"/> Riba-Pak®	<input type="radio"/> 600mg AM and 600mg PM (1200mg) <input type="radio"/> 600mg AM and 400mg PM (1000mg) <input type="radio"/> 400mg AM and 400mg PM (800mg) <input type="radio"/> Other Dosage: _____ mg AM and _____ mg PM	28 day supply	Refills																																				
<input type="radio"/> Ribavirin 200mg	Take _____ mg AM and _____ mg PM	28 day supply	Refills																																				
Hepatitis B Oral Therapies	<input type="radio"/> Baraclude® 0.5mg tablet <input type="radio"/> Baraclude® 1mg tablet <input type="radio"/> Hepsera® 10mg tablet <input type="radio"/> Epivir HBV® 100mg tablet <input type="radio"/> Tyzeka® 600mg tablet <input type="radio"/> Other _____ <input type="radio"/> 1 tablet PO QD <input type="radio"/> Alt. directions: _____	30 day supply	Refills																																				
Anemia or Neutropenia	<input type="radio"/> Procrit® vial <input type="radio"/> Epogen® vial <input type="radio"/> Neulasta® PFS <input type="radio"/> Neupogen® PFS <input type="radio"/> Aranesp® Sureclick™ Autoinjector Strength _____ Directions _____	28 day supply	Refills																																				
Other Medications:	Directions _____	Qty	Refills																																				

Deliver to:  Patient's home  OMD's office  1<sup>st</sup> dose to MD's office, remaining refills to patient home Injection training needed?  Yes  No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

Prescriber name or signature \_\_\_\_\_ Office Contact Name (Nurse, MA, Other) \_\_\_\_\_ Preferred phone number & extension \_\_\_\_\_ Date \_\_\_\_\_