



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

Prescriber Information

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

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"/> <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"/> >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"/> Ribavirin 200mg	Take _____ mg AM and _____ mg PM	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)	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 MD's office 1st 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 _____