



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® Prefilled Syringe	Inject: <input type="radio"/> 180mcg SC QW <input type="radio"/> 135mcg SC QW <input type="radio"/> 90mcg SC QW	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																																		
<input type="radio"/> Incivek tablets (telaprevir- Vertex)	<input type="radio"/> Take 750mg PO TID with food [<i>not low fat</i>] (doses spaced 7-9 hours apart)	28 day supply	Refills																																		
<input type="radio"/> Victrelis capsules (boceprevir-Merck)	<input type="radio"/> Take 800mg PO TID with food (doses spaced 7-9 hours apart) starting _____ (date)	28 day supply	Refills																																		
Other medication	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 _____