

HEPATITIS C REFERRAL FORM

54 Conchester Road Glen Mills, PA 19342
 1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Last Name _____ SS# _____ DOB _____ Height _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

Previously treated No Yes, what drugs _____ Interferon Yes No # of Weeks _____ relapsed partial response null response
 ICD-9 Code 070.54 HCV (Chronic) Liver Biospsy Yes No Date _____ Results _____
 HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PEG INTRON REDIPEN VIAL
 Weight (lbs) Strength (Dose) Volume to inject
 < 88 50mcg/0.5ml 0.5ml SQ/QW
 89-110 80mcg/0.5ml 0.5ml SQ/QW
 111-132 80mcg/0.5ml 0.5ml SQ/QW
 133-165 120mcg/0.5ml 0.5ml SQ/QW
 166-187 120mcg/0.5ml 0.5ml SQ/QW
 >187 150mcg/0.5ml 0.5ml SQ/QW
 Quantity: 1 month 3 months Refill x _____

RIBAVIRIN® | RIBAPAK
 Weight (lbs)
 103-131 800mg PO Daily; 400mg QAM, 400mg QPM
 132-162 1000mg PO Daily; 600mg QAM, 400mg QPM
 > 162 1200mg PO Daily; 600mg QAM, 600mg QPM
 Ribavirin 200mg Sig _____
 Quantity _____ Refill x _____

NEUPOGEN
 300 mcg 480mcg QW BIW
 Refill x _____ Months Sig _____
PROCRIT 10,000IU 20,000IU 40,000IU
 Refill x _____ Months Sig _____

PEGASYS
 ProClick 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
 Pre-Filled Syringe 180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly
 Other _____
 Quantity: 1 month 3 month Refill x _____

INCIVEK 750mg (2 x 375mg) 1 month 3 month Refill x 2
 Directions: Tid with food for 12 wks w/peginterferon and ribavirin
VICTRELIS 800mg (4 x 200mg) 1 month 3 month Refill x _____
 Directions: Tid with food, start day 29 of peginterferon and ribavirin

HEPATITIS B ORAL THERAPIES
 Baraclude 1 Tablet po QD
 0.5mg 1.0mg Additional Directions: _____
 Epiriv HBV 100mg
 Hepsara 10mg Quantity _____
 Tyzeka 600mg 1 Month 3 Month

INFERGEN 9mcg TIW for _____ Weeks 9mcg QD Other: _____
 15mcg TIW for _____ Weeks 12mcg QD Refill x _____ Months

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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