

TODAY'S DATE:
DATE SHIPMENT NEEDED:
<input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION OF THERAPY
SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____

Hepatitis Referral Form

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME):		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
CAN PHARMACY LEAVE A VOICEMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO VOICEMAIL PHONE #:			
PHYSICIAN NAME:		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

PRESCRIPTION INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
SECONDARY INSURANCE:		GROUP#:	PHONE#:

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: HEPATITIS B HEPATITIS C (Chronic) OTHER _____ VIRAL LOAD/DATE: _____

GENOTYPE: _____ CO-INFECTED: _____ NAIVE RELAPSER NON-RESPONDER

PRESCRIPTION INFORMATION

<p><input type="checkbox"/> Infergen®</p> <p><input type="checkbox"/> 9 mcg subQ day <input type="checkbox"/> 9 mcg subQ 3x/week</p> <p><input type="checkbox"/> 15 mcg subQ day <input type="checkbox"/> 15 mcg subQ 3x/week</p> <p><input type="checkbox"/> Other _____</p> <p>Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Peg-Intron®</p> <p><input type="checkbox"/> RediPen PAK <input type="checkbox"/> Vial (4) Refills: _____</p> <p><input type="checkbox"/> <40 kg 50 mcg/0.5 mL 0.5 mL subQ weekly</p> <p><input type="checkbox"/> 40-50 kg 80 mcg/0.5 mL 0.4 mL subQ weekly</p> <p><input type="checkbox"/> 51-60 kg 80 mcg/0.5 mL 0.5 mL subQ weekly</p> <p><input type="checkbox"/> 61-75 kg 120 mcg/0.5 mL 0.4 mL subQ weekly</p> <p><input type="checkbox"/> 76-85 kg 120 mcg/0.5 mL 0.5 mL subQ weekly</p> <p><input type="checkbox"/> >85 kg 150 mcg/0.5 mL 0.5 mL subQ weekly</p> <p><input type="checkbox"/> Pegasys®</p> <p><input type="checkbox"/> 180 mcg/0.5 mL syringe subQ weekly</p> <p><input type="checkbox"/> 180 mcg/1 mL vial subQ weekly</p> <p><input type="checkbox"/> Other _____</p> <p>Qty: _____ Refills: _____</p> <p>Supportive Care</p> <p><input type="checkbox"/> Procrit®</p> <p>Sig: _____</p> <p>Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Neupogen®</p> <p>Sig: _____</p> <p>Qty: _____ Refills: _____</p>	<p><input type="checkbox"/> Ribasphere® RibaPak®</p> <p><input type="checkbox"/> 800 mg/day Sig: 400 mg PO BID</p> <p><input type="checkbox"/> 1000 mg/day Sig: 600 mg PO QAM & 400 mg PO QPM</p> <p><input type="checkbox"/> 1200 mg/day Sig: 600 mg PO BID</p> <p>Qty: _____ 56 Refills: _____</p> <p><input type="checkbox"/> Ribavirin 200 mg <input type="checkbox"/> Capsules <input type="checkbox"/> Tablets</p> <p>Sig: _____</p> <p>Qty: _____ Refills: _____</p> <p>Hepatitis C Oral Antivirals</p> <p><input type="checkbox"/> Victrelis® 800 mg PO TID Qty: 336 (200 mg Capsules)</p> <p><input type="checkbox"/> Incivek® 750 mg PO TID Qty: 168 (375 mg Tablets)</p> <p>Refills: _____</p> <p>Hepatitis B Oral Antivirals</p> <p><input type="checkbox"/> EpiVir-HBV® 100 mg <input type="checkbox"/> Baraclude® 0.5 mg <input type="checkbox"/> Baraclude® 1 mg</p> <p><input type="checkbox"/> Hepsera® 10 mg <input type="checkbox"/> Viread® 300 mg <input type="checkbox"/> Tyzeka® 600 mg</p> <p>Sig: _____</p> <p>Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Other Medication _____</p> <p>Sig: _____</p> <p>Qty: _____ Refills: _____</p>
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If you would like brand names, please write "Brand Medically Necessary". Please note Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.

I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agents for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

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