



Phone: 1-888-315-3395
 Fax: 1-888-315-3270

HEPATITIS C REFERRAL FORM

Attn: _____

Today's Date: _____ Need By Date: _____
 Ship To: Patient Physician * All the supplies including a syringe and needles will be dispensed if needed.

Patient Information	Physician Information
Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home#: _____ Work #: _____ Cell #: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM Primary Language: _____ Date of Birth: _____ Allergies: _____ <input type="checkbox"/> NKDA Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security #: _____ Weight: _____ Height: _____ Ethnicity: _____	Physician: _____ Practice: _____ Address: _____ Phone: _____ Fax: _____ State Lic# _____ DEA# _____ NPI# _____ Contact: _____ *Injection Training <input type="checkbox"/> Office to Provide <input type="checkbox"/> Axium to Coordinate <i>RN/LPN to teach administration of injectable to caregiver/patient (in accordance with state laws)</i>

Insurance	Primary Insurance: _____ Employer: _____ Phone: _____	Cardholder Name: _____ ID#: _____ Group#: _____
	Secondary Insurance: _____ Phone: _____ ID#: _____ Group#: _____	*Please provide copy of insurance card*

Statement of Medical Necessity	Attach Supporting Labs																				
Primary Diagnosis: <input type="checkbox"/> 070.54 Hepatitis C (Chronic) Genotype: 1a 1b 2 3 4 HIV Co Infected: <input type="checkbox"/> Yes <input type="checkbox"/> No Compensated Cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Baseline HCV-RNA</td> <td>DATE:</td> <td>RESULT:</td> <td>IU/mL</td> </tr> <tr> <td>IL28B</td> <td>DATE:</td> <td>RESULT</td> <td><input type="checkbox"/> C/C <input type="checkbox"/> C/T <input type="checkbox"/> T/T</td> </tr> </table> Prev. Treated with Interferon? <input type="checkbox"/> No, patient is <u>Naïve</u> <input type="checkbox"/> YES If yes, patient is a: <input type="checkbox"/> Partial Responder <input type="checkbox"/> Relapser <input type="checkbox"/> Null Response	Baseline HCV-RNA	DATE:	RESULT:	IU/mL	IL28B	DATE:	RESULT	<input type="checkbox"/> C/C <input type="checkbox"/> C/T <input type="checkbox"/> T/T	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">List Other Medications (may submit separately)</th> </tr> <tr> <th style="width: 70%;">Drug Name</th> <th>Dose/Frequency</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	List Other Medications (may submit separately)		Drug Name	Dose/Frequency								
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Interferon Rx	Ribavirin Rx	Protease Inhibitor Rx *Genotype 1																								
<input type="checkbox"/> Pegasys PFS Conv. Pack <input type="checkbox"/> Pegasys Vials SIG: <input type="checkbox"/> Inject 180 mcg SQ weekly <input type="checkbox"/> _____ QTY: 4 doses Refill: _____	<input type="checkbox"/> Ribasphere RibaPak™ (ribavirin) <input type="checkbox"/> 400/400 <input type="checkbox"/> 400/600 <input type="checkbox"/> 600/600 SIG: <input type="checkbox"/> Take 1 tablet q AM and 1 tablet q PM <input type="checkbox"/> _____ QTY: 56 Tablets Refill: _____	<input type="checkbox"/> Incivek™ 375mg Tablet (telaprevir) SIG: Take 2 tablets (750mg) po TID (7-9 hours apart) with food (NOT low-fat). QTY: 168 Tablets Refill: 2																								
<input type="checkbox"/> Peg-Intron Redipen <input type="checkbox"/> Peg-Intron Vial <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Check</th> <th>Weight (lbs)</th> <th>SIG:</th> </tr> </thead> <tbody> <tr><td> </td><td>≤100</td><td>Inject 40 mcg SQ weekly</td></tr> <tr><td> </td><td>101-124</td><td>Inject 50 mcg SQ weekly</td></tr> <tr><td> </td><td>125-159</td><td>Inject 64 mcg SQ weekly</td></tr> <tr><td> </td><td>160-195</td><td>Inject 80 mcg SQ weekly</td></tr> <tr><td> </td><td>196-234</td><td>Inject 96 mcg SQ weekly</td></tr> <tr><td> </td><td>235-300</td><td>Inject 120 mcg SQ weekly</td></tr> <tr><td> </td><td>301-353</td><td>Inject 150 mcg SQ weekly</td></tr> </tbody> </table> QTY: 4 doses Refill: _____	Check	Weight (lbs)	SIG:		≤100	Inject 40 mcg SQ weekly		101-124	Inject 50 mcg SQ weekly		125-159	Inject 64 mcg SQ weekly		160-195	Inject 80 mcg SQ weekly		196-234	Inject 96 mcg SQ weekly		235-300	Inject 120 mcg SQ weekly		301-353	Inject 150 mcg SQ weekly	<input type="checkbox"/> Ribavirin 200mg Caps <input type="checkbox"/> Tabs SIG: <input type="checkbox"/> 800 mg/day: 2 po AM & 2 po PM <input type="checkbox"/> 1000 mg/day: 3 po AM & 2 po PM <input type="checkbox"/> 1200 mg/day: 3 po AM & 3 po PM <input type="checkbox"/> _____ QTY: 28 day supply Refill: _____	<input type="checkbox"/> Victrelis™ 200mg Capsules (boceprevir) SIG: <input type="checkbox"/> INITIAL: After 4 week lead-in with Peg/Rib, Take 4 capsules (800mg) po TID (every 7-9 hours) with food. Refill: 0 <input type="checkbox"/> MAINTENANCE: Take 4 capsules (800mg) po TID (every 7-9 hours) with food. QTY: 336 Capsules Refill: _____
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Supportive Meds	OTHER: _____
<input type="checkbox"/> Infergen Vial SIG: <input type="checkbox"/> Inject 9mcg/0.3mL SQ QD <input type="checkbox"/> Inject 15mcg/0.5mL SQ TIW <input type="checkbox"/> _____ QTY: 28 day supply Refill: _____	<input type="checkbox"/> Procrit Vial <input type="checkbox"/> Epogen Vial SIG: _____ QTY: _____ Refill: _____
<input type="checkbox"/> Neupogen Singlejects <input type="checkbox"/> Neupogen Vials SIG: _____ QTY: _____ Refill: _____	SIG: _____ QTY: _____ Refill: _____ <i>If you would like brand name, please write Medically Necessary.</i>

By signing this form, Physician authorizes Axium Healthcare Pharmacy to act as his/her agent in the initiation and execution of patient's insurance PA process and agrees to provide Axium all lab results to assist with identification of treatment duration and/or futility (Incivek) TW4 & TW12 / (Victrelis) TW4, TW8, TW12, TW24.

Physician Signature: _____ Date: _____

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