



Hepatitis C Virus (HCV) Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND
FAX TO: 1-888-773-7386 or Call: 1-866-773-HEPC (4372)

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information New Rx Refill

Name: _____ Phone #1: _____ Phone #2: _____
 Address: _____ Allergies: _____ No Known Allergies
 City: _____ ST: _____ Zip: _____ Health Conditions: _____
 Date of Birth (mm/dd/yyyy): ____/____/____ Expected Start Date: ____/____/____

Statement of Medical Necessity

Patient Weight: _____ lbs kg Primary Diagnosis: _____ ICD9 Code: _____

HCV Genotype: _____ Comorbidities: _____

Is patient on or previously been on interferon/ribavirin therapy? If yes, name the product(s) and date range(s) of treatment: _____
 For Hep C Diagnosis: State reason if patient is not on combination therapy using a Pegylated Interferon with Ribavirin: _____

Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery Home Delivery for Self Injection/Administration
 Home Delivery for Home Health Administration
 Other: _____ Contact: _____
 Phone #: _____
 Address: _____

Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: _____ Secondary: _____
 Insured: _____ Insured: _____
 ID #: _____ Group #: _____ ID #: _____ Group #: _____
 Phone #: _____ Rx Drug Card #: _____ Phone #: _____ Rx Drug Card #: _____
 Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____ Rx Bin #: _____ Rx PCN #: _____ Rx Grp #: _____

Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: _____ Office Contact: _____
 Address: _____ NPI #: _____ DEA #: _____
 City: _____ ST: _____ Zip: _____ Phone #: _____ Fax #: _____

2. COMPLETE THE FOLLOWING RX FORM -OR- TAPE RX HERE

Rx		Date: ____/____/____	
Drug Name/Form/Strength	Qty	Directions for Use	Refills
PEGASYS® Injection <input type="checkbox"/> 180mcg/1.0 mL Vial <input type="checkbox"/> 180mcg/0.5 mL Prefilled Syringe			
PEG-Intron® Injection <input type="checkbox"/> Redipen <input type="checkbox"/> Vial <input type="checkbox"/> 50mcg <input type="checkbox"/> 80mcg <input type="checkbox"/> 120mcg <input type="checkbox"/> 150mcg			
Ribapak Compliance Pack <input type="checkbox"/> 800 mg/day <input type="checkbox"/> 1000 mg/day <input type="checkbox"/> 1200 mg/day <input type="checkbox"/> Ribavirin 200mg cap <input type="checkbox"/> Ribavirin 200mg tab			
Protease Inhibitor <input type="checkbox"/> (Please list drug name & strength)			
Aranesp® <input type="checkbox"/> PFS <input type="checkbox"/> Vial <input type="checkbox"/> 25mcg <input type="checkbox"/> 40mcg <input type="checkbox"/> 60mcg <input type="checkbox"/> 100mcg <input type="checkbox"/> 150mcg <input type="checkbox"/> 200mcg <input type="checkbox"/> 300mcg			
Erythropoietin alpha <input type="checkbox"/> 10,000 units <input type="checkbox"/> 20,000 units <input type="checkbox"/> 40,000 units			
Other:			
Needles Gauge: ____ Inches: ____ Quantity: ____ Refills: ____		Syringes Volume: ____ Inches: ____ Quantity: ____ Refills: ____	
X _____ Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted		X _____ Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted	