

HEPATITIS C

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

INSURANCE INFORMATION

Primary/Medical Insurance		Secondary/Pharmacy Insurance		
Cardholder Name & ID # (If Not Patient)		Cardholder Name & ID # (If Not Patient)		
Group/Policy #		Group/Policy #		
Insurance Telephone # (+Area Code)		Insurance Telephone # (+Area Code)		
Employer		Medicaid #		

ALTERNATE SHIPPING ADDRESS

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address	
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)
 070.54 Hepatitis C (Chronic) Date of Diagnosis / /
 Other ICD-9(s) Diagnoses _____
Genotype 1 2 3 4 Other _____
HCV RNA (Baseline) _____ Copies/ml Date / /
HCV RNA (12 wk If Applicable) _____ Copies/ml Date / /
 Has the Patient Had Diagnosis of Chronic Hepatitis C Persistence for 6 Months or More? Yes No
 Has the Patient Been Previously Treated for Hepatitis C? Yes No
 Has Patient Been Counseled on Teratogenic Effects of Ribavirin? Yes No
 Ship Meds to Patient's Home Patient's Work Physician's Office
 Patient Weight _____ kg. or _____ lbs. Date / /

INJECTION TRAINING:

Injection Training Will Be/Has Been Conducted By Physician's Office? Yes No
First Dose of Medication Will Be/Has Been Administered at Physician's Office? Yes No

Rx
 Pegasys® Pre-filled Syringes or Vials (*Ancillary Supplies Provided as Needed*)
 SIG: Inject 180 mcg 135 mcg 90 mcg Other _____ SQ Once Weekly
 30 Day Supply Other _____ Refill x _____
 Enroll in PegassistSM Hep C Support Program
 PEG-Intron® Redipen® or Vials (*Ancillary Supplies Provided as Needed*)
 Dose 50mcg/0.5mL 80mcg/0.5mL 120mcg/0.5mL 150mcg/0.5mL
 SIG: Inject 0.4ml SQ Once Weekly 0.5ml SQ Once Weekly
 30 Day Supply Other _____ Refill x _____
 Enroll in Be in Charge® Hep C Support Program
 Infergen® Vials (*Ancillary Supplies Provided as Needed*)
 SIG: Inject 9 mcg 15 mcg SQ 3 Times Weekly or Other _____
 30 Day Supply Other _____ Refill x _____
 Enroll in Aspire® Hep C Support Program
 Ribavirin Tablets or Capsules or Other _____
 SIG: Daily In 2 Divided Doses PO 800 mg 1000 mg 1200 mg Other _____
 30 Day Supply Other _____ Refill x _____
 Aranesp® **Epogen**® **Procrit**® **Neupogen**® **Leukine**® **Neulasta**® **Neumega**®
 SIG: Inject _____ (Dose & Frequency) Qty _____ Refill x _____
 Rx - Other _____

Prescriber's Signature _____ **Date** _____

PHYSICIAN SPECIALTY: Gastroenterologist Other (Specify) _____

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.
Thank you for choosing Caremark!