

PATIENT REFERRAL FORM

(electronically transmitted prescription)

Prescriber: _____ DEA# _____

Address: _____

City: _____ State: _____ Zip: _____

() _____ - _____ (ph) () _____ - _____ (fax) Date: _____

REQUIRED! Date Need by: _____ Deliver to: Patient MD Office Other: _____

PATIENT INFO. Attach copy of patient's demographic sheet or complete.

Patient Name _____ Home Phone _____

Address _____ Daytime Phone _____

City _____ State _____ Zip _____ DOB _____ SSN _____

INSURANCE INFO. Attach copy of patient's insurance card (both sides), insurance info. from medical record or complete.

Primary Insurance _____ Secondary Insurance _____

Name of Insured _____ Name of Insured _____

Policy/Drug Card # _____ Policy/Drug Card # _____

Group # _____ Group # _____

Phone # _____ Phone # _____

MEDICAL INFO.

ICD-9 Codes 070.51 Chronic Hepatitis C _____ Weight _____ Allergies _____

PRESCRIPTIONS

Peg-Intron	Strength	Dose	Quantity
<input type="checkbox"/> REDI-pen	<input type="checkbox"/> 50mcg/0.5ml	<input type="checkbox"/> 0.4ml SC QWEEKLY	# _____ Pens or Vials (Each pen or vial = 1-week supply)
<input type="checkbox"/> Vials	<input type="checkbox"/> 80mcg/0.5ml	<input type="checkbox"/> 0.5ml SC QWEEKLY	REFILLS X _____
	<input type="checkbox"/> 120mcg/0.5ml		
	<input type="checkbox"/> 150mcg/0.5ml		

Pegasys	Strength	Dose	Quantity
<input type="checkbox"/> Pre-Filled Syringe Conv. Pak	180mcg/0.5ml	<input type="checkbox"/> 0.5ml SC QWEEKLY	# _____ Syringes or Vials (Each syringe or vial = 1-week supply)
<input type="checkbox"/> Convenience Pak	180mcg/1ml	<input type="checkbox"/> 1ml SC QWEEKLY	REFILLS X _____
<input type="checkbox"/> Single Dose Vials	180mcg/1ml	<input type="checkbox"/> 1ml SC QWEEKLY	

Riba-Pak	Dose	Quantity
<input type="checkbox"/> Ribavirin 400mg/400mg Tablets	1x 400mg AM and 1x 400mg PM	_____ Days Supply
<input type="checkbox"/> Ribavirin 600mg/400mg Tablets	1x 600mg AM and 1x 400mg PM	
<input type="checkbox"/> Ribavirin 600mg/600mg Tablets	1x 600mg AM and 1x 600mg PM	REFILLS X _____

Ribavirin	Dose	Total Daily Dose	Quantity
<input type="checkbox"/> Ribavirin 200mg Tablets	_____ AM _____ PM	<input type="checkbox"/> 1200mg	_____ Days Supply
<input type="checkbox"/> Ribavirin 400mg Tablets	(Note # Caps or Tabs/dose)	<input type="checkbox"/> 1000mg	
<input type="checkbox"/> Ribavirin 600mg Tablets	<input type="checkbox"/> Rebetol 200mg Capsules	<input type="checkbox"/> 800mg	
<input type="checkbox"/> Ribavirin 200mg Capsules	<input type="checkbox"/> Copegus 200mg Tablets	<input type="checkbox"/> 600mg	REFILLS X _____

Infergen	Vial Strength	Dose	Quantity
	<input type="checkbox"/> 9mcg/0.3ml Single Dose Vials	<input type="checkbox"/> 9mcg (0.3ml) SC 3 x per week	# _____ Vials (Vials packaged in boxes of 6=2wk supply)
	<input type="checkbox"/> 15mcg/0.5ml Single Dose Vials	<input type="checkbox"/> 15mcg (0.5ml) SC 3 x per week	REFILLS X _____
		<input type="checkbox"/> _____mcg SC _____ x per week	

Procrit	Vial Strength	Dose	Quantity
	<input type="checkbox"/> 10,000u/1ml Single Dose Vials	<input type="checkbox"/> 1ml SC 3 x per week	# _____ Vials
	<input type="checkbox"/> 20,000u/1ml Single Dose Vials	<input type="checkbox"/> 1ml SC _____ x per week	REFILLS X _____
	<input type="checkbox"/> 40,000u/1ml Single Dose Vials		

Neupogen	Vial Strength	Dose	Quantity
	<input type="checkbox"/> 300mcg/1ml Single Dose Vials	<input type="checkbox"/> Inject _____ml SC daily	_____ days supply
	<input type="checkbox"/> 480mcg/1.6ml Single Dose Vials	starting on _____	
	<input type="checkbox"/> 300mcg/0.5ml Pre-Filled Syringe	(Date)	
	<input type="checkbox"/> 480mcg/0.8ml Pre-Filled Syringe	<input type="checkbox"/> Other _____	Refills X _____

Baraclude	Hepsera
<input type="checkbox"/> 0.5mg Tablets	<input type="checkbox"/> 10mg Tablets
<input type="checkbox"/> 1 mg Tablets	<input type="checkbox"/> One (1) tablet daily.
<input type="checkbox"/> .05mg/ml Oral Soln.	# _____ tablets
<input type="checkbox"/> One (1) tablet daily.	# _____ ml
<input type="checkbox"/> Other _____	REFILLS X _____
<input type="checkbox"/> _____ml daily.	REFILLS X _____

Epivir-HBV	Additional Meds
<input type="checkbox"/> One (1) tablet daily.	_____ # _____ REFILL _____
<input type="checkbox"/> Other _____	_____ # _____ REFILL _____
<input type="checkbox"/> _____ml daily.	
REFILLS X _____	

Prescriber Signature _____

Interchange is mandated unless the practitioner writes the words "no substitution" in the above space

FAX COVER SHEET



315 Pleasant Street
Building 1, 6th floor
Fall River, MA 02721
800-218-5688 (phone)

800-830-5292 (fax)

ATTENTION: Please remember to include the Need by Date and delivery location to help us deliver your patient's order on time.

Date: _____

Senders Name: _____

Direct Phone #: _____

My fax # is: _____

We are transmitting a total of _____ pages, including this cover page.

Additional Notes: