

Hepatitis Specialty Treatment Order Form



61 Doctor's Park • Cape Girardeau, MO 63703
866-936-1999 • Fax (573) 335-7233

Prescriber's Name: _____ MD / DO / NP / PA
Address: _____
City _____ State _____ Zip _____
Office Contact: _____ Phone# _____ Fax# _____
NPI: _____ DEA: _____ License: _____

PATIENT INFORMATION

Send updates to Fax E-mail to _____ Text to Phone# _____

Patient's Name: _____ SS# _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work or Cell: _____ Emergency Contact: _____

Allergies: _____ Sex: M ___ F ___ Wt: _____ Ht: _____ Diabetic: Y ___ N ___

Patient previously on treatment: Y ___ N ___ Date: _____

Primary Insurance: _____ Policy# _____

Insured: _____ Group _____

Phone: _____ BIN# _____ PCN# _____

*** Please include current patient medication list with referral ***

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: 070.32 Hepatitis B 070.54 Hepatitis C (Chronic) 042 HIV Date of Diagnosis: _____
(Refer to HIV order form)

Biopsy: Y ___ or N ___ Stage _____ Grade _____ Genotype: _____ Initial Viral Load: _____ M copies/ml _____ HIV: Y ___ or N ___

TREATMENT ARRANGEMENTS

Ship Meds: Home Doctors Office Lab in Box: Y ___ or N ___

Anticipated Start Date _____ Teaching by: Special Design Healthcare Drs. Office Other _____

PEG INTRON Redipen

28 Day Supply

Dose to be injected SQ once weekly:

- | | |
|---|---|
| <input type="checkbox"/> 50 mcg/0.5ml - 0.5ml (50mcg) | Recommended Pt Wt Range
<88 lbs / <40 kg |
| <input type="checkbox"/> 80 mcg/0.5ml - 0.4ml (64mcg) | 88-110 lbs / 40-50 kg |
| <input type="checkbox"/> 80 mcg/0.5ml - 0.5ml (80mcg) | 111-132 lbs / 51-60 kg |
| <input type="checkbox"/> 120 mcg/0.5ml - 0.4ml (96mcg) | 133-165 lbs / 61-75 kg |
| <input type="checkbox"/> 120 mcg/0.5ml - 0.5ml (120mcg) | 166-187 lbs / 76-85 kg |
| <input type="checkbox"/> 150 mcg/0.5ml - 0.5ml (150mcg) | >187 lbs / >85 kg |

Refills x _____

- Witch Hazel prn as needed
 Tucks Pads prn as needed
 1% Hydrocortizone Cream prn as needed

RIBAVIRIN

Recommended Dosing Guidelines

Dose per day	Patient Weight
600 mg	<88 lbs / <40 kg
800 mg	88-141 lbs / 40-64 kg
1000 mg	142-187 lbs / 65-85 kg
1200 mg	188-231 lbs / 86-105 kg
1400 mg	>231 lbs / >105 kg

Ribasphere Ribapak

28 Day Supply

- 1400mg po daily, (1200mg per day Ribapak dosing plus Ribasphere 200mg tablet po q AM)
 1200mg po daily 600mg tablet in am, 600mg tablet in pm
 1000mg po daily 600mg tablet in am, 400mg in pm
 800mg po daily 400mg tablet in am, 400mg tablet in pm
 Other _____

Refills x _____

Ribasphere 200mg tablets

28 Day Supply

- 1400mg po daily, _____ tabs q am & _____ tabs q pm with food
 1200mg po daily, _____ tabs q am & _____ tabs q pm with food
 1000mg po daily, _____ tabs q am & _____ tabs q pm with food
 800mg po daily, _____ tabs q am & _____ tabs q pm with food
 600mg po daily, _____ tabs q am & _____ tabs q pm with food
 Other _____

Refills x _____

PEGASYS Prefilled Syringes

28 Day Supply

- 180 mcg SQ Weekly
 135 mcg SQ Weekly
 90 mcg SQ Weekly
 Other _____
Refills x _____

INCIVEK (Telaprevir)

28 Day Supply

375mg tablets
Dose: 2250mg daily, 2 tabs three times a day
Directions: _____

Refills x _____

NEUPOGEN

28 Day Supply

- 300 mcg Sub Q weekly or twice weekly
480 mcg Sub Q weekly or twice weekly
 Other _____
Refills x _____

OTHER MEDICATIONS

- | | |
|--|------------------|
| <input type="checkbox"/> Sorafenib (Nexavar) | Dose _____ |
| <input type="checkbox"/> Alinia | Directions _____ |
| <input type="checkbox"/> Adefovir (Hepsera) | _____ |
| <input type="checkbox"/> Entecavir (Baraclude) | _____ |
| <input type="checkbox"/> Tenofovir (Viread) | _____ |
| <input type="checkbox"/> Telbivudine (Tyzeka) | Quantity _____ |
| <input type="checkbox"/> Other _____ | Refills x _____ |

INFERGEN

28 Day Supply

- 15 mcg SubQ every day
 9 mcg SubQ every day
 Other _____
Refills x _____

VICTRELIS (Boceprevir)

28 Day Supply

200mg Capsules
Dose: 2400mg daily, 4 caps three times a day
Directions: _____
Start 4 weeks after initiation of standard therapy
Refills x _____

EPOETIN ALFA

EPOGEN

28 Day Supply

- 20,000 IU subQ Twice weekly
 Other _____
Refills x _____
PROCRIPT Sig: SQ Weekly
28 Day Supply
 10,000 IU 20,000 IU 40,000 IU
 Other _____
Refills x _____

By signing this form and utilizing our services, you are authorizing SDHC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: _____

May Substitute

Dispense as Written

Date: _____