Hepatitis C Therapies
Fax to 866-406-4215

Customer Service: 866-406-4209

MEDICA®

• Facsimile not valid for C-II prescriptions.

Patient Information Please type or print clearly.

Name ____

Address ____

City ____

State ____ ZIP Code ____

DOB ____

Home Phone w/area code ____

Work Phone w/area code ____

Insurance Information ☐ Major Medical ☐ Rx Benefit

Please attach a copy of card(s) if possible.

Primary Insurer ____

Cardholder ____

DOB ____ Cardholder ID # ____

Group # ____ RxCard ID # ____

RxBin # ____ RxGroup # ____

Phone w/area code ____ Fax w/area code ____

Medical Assessment

Therapy Start Date ____

Diagnosis ____

ICD-9 Code ____

Allergies ____

Weight (kg/lb) ____

Creatine Clearance (mL/min) ____

ALT ____ AST ____

HCV RNA ____

Physician Information

MD Name ____

Address ____

City ____ State ____ Zip Code ____

Phone w/area code ____

Fax w/area code ____

UPIN ____ DEA # ____

☐ **Please acknowledge receipt of this fax.**

PHYSICIAN SIGNATURE REQUIRED

I certify that the therapy is medically necessary and the information on this form is accurate to the best of my knowledge.

Signature ____ Date ____

Form Faxed by ____
Print Full Name

☐ **PEG-INTRON®**

☐ Single Redipen™ ☐ Redipen™ Pak 4 ☐ Single Vial

___ 50 mcg/0.5 mL ___ 120 mcg/0.5 mL

___ 80 mcg/0.5 mL ___ 150 mcg/0.5 mL

Volume per injection: ___ 0.4 mL ___ 0.5 mL ___ Other

Directions ____

Quantity ____ Refill x ____

☐ **REBETOL® 200 mg Capsule**

___ 600 mg po daily: 200 mg qAM and 400 mg qPM

___ 800 mg po daily: 400 mg qAM and 400 mg qPM

___ 1,000 mg po daily: 400 mg qAM and 600 mg qPM

___ 1,200 mg po daily: 600 mg qAM and 600 mg qPM

___ Other ____

Quantity ____ Refill x ____

☐ **PEGASYS®**

___ Prefilled syringe monthly pack (180 mcg/0.5 mL)

___ Single vial (180 mcg/1 mL)

Directions ____

Quantity ____ Refill x ____

☐ **COPEGUS™ 200 mg Tablets**

___ 600 mg po daily: 200 mg qAM and 400 mg qPM

___ 800 mg po daily: 400 mg qAM and 400 mg qPM

___ 1,000 mg po daily: 400 mg qAM and 600 mg qPM

___ 1,200 mg po daily: 600 mg qAM and 600 mg qPM

___ Other ____

Quantity ____ Refill x ____

☐ **PROCRIT®** ☐ **EPOGEN®**

1 mL Single-Dose, Preservative-free Solution

☐ 2,000 Units/mL ☐ 3,000 Units/mL ☐ 4,000 Units/mL

☐ 10,000 Units/mL ☐ 40,000 Units/mL

2 mL Multidose, Preserved Solution

☐ 10,000 Units/mL

1 mL Multidose, Preserved Solution

☐ 20,000 Units/mL

Directions to be given: ☐ SC ☐ IV ____

Quantity ____ Refill x ____

☐ **INFERGEN™**

___ 9 mcg/0.3 mL

___ 15 mcg/0.5 mL

Directions ____

Quantity ____ Refill x ____

☐ **NEUPOGEN™**

___ 300 mcg/0.5 mL Syringe ___ 300 mcg/mL Vial

___ 480 mcg/0.8 mL Syringe ___ 480 mcg/1.6 mL Vial

Directions ____

Quantity ____ Refill x ____

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