



Hepatitis C Enrollment Form

Phone: 1-866-516-4121 Fax: 314-652-4126

Last Name	First Name	Sex	Date of Birth	Today's Date	Date Needed
Home Address			City	State	Zip
Shipping Address (if different from home address)				Address	City State Zip
Home Phone Number ()		Alternate Phone Number ()		DEA #	
Member ID					
Delivery Instructions: Home <input type="checkbox"/> Work <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> _____					
Primary Insurance Company			Phone	Name of Insured/SSN	Employer Name/ID Number Group Number
Secondary/Supplemental Insurance Company			Phone	Name of Insured/SSN	Employer Name/ID Number Group Number
Primary Diagnosis: ICD-9 Code <input type="checkbox"/> 070.54 <input type="checkbox"/> Other _____ Estimated length of treatment: <input type="checkbox"/> 24 weeks <input type="checkbox"/> 48 weeks					
Pt Wt _____ kg or _____ lbs on date _____ Allergies _____ <input type="checkbox"/> NKA					
HCN RNA (VL) _____ ALT _____ AST _____ Platelet Count _____ ANC _____ H/H _____ TSH _____					
Patient Training: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Nursing Visit <input type="checkbox"/> Other: _____					
Allergies:				Special Instructions: (non-english speaking patients, etc.)	

PEG-INTRON INJECTION: <input type="checkbox"/> Vials <input type="checkbox"/> Pen <input type="checkbox"/> 50 mcg/0.5 mL Kit SQ weekly <input type="checkbox"/> 80 mcg/0.5 mL Kit SQ weekly <input type="checkbox"/> 120 mcg/0.5 mL SQ weekly <input type="checkbox"/> 150 mcg/0.5 mL Kit SQ weekly Volume per Injection: <input type="checkbox"/> 0.4 mL <input type="checkbox"/> 0.5 mL <input type="checkbox"/> Other _____ Quantity: _____ Kits Refill x _____	PEGASYS: <input type="checkbox"/> Vials <input type="checkbox"/> Prefilled Directions: Inject 180 mcg SQ every week Other: _____ Quantity: _____ (28 days) Refill x _____	OTHER: Drug: _____ Directions: _____ Quantity: _____ Refill x _____
Ribavirin 200 mg: Directions: <input type="checkbox"/> 600 mg po daily: 200 mg QAM, 400 mg QPM <input type="checkbox"/> 800 mg po daily: 400 mg QAM, 400 mg QPM <input type="checkbox"/> 1000 mg po daily: 400 mg QAM, 600 mg QPM <input type="checkbox"/> 1200 mg po daily: 600 mg QAM, 600 mg QPM <input type="checkbox"/> Other: _____ Refill x _____	Quantity # 84 # 112 # 140 # 168 # _____	OTHER: Drug: _____ Directions: _____ Quantity: _____ Refill x _____
PHYSICIAN SIGNATURE REQUIRED		
Physician Signature: _____ <input type="checkbox"/> Dispense as Written <input type="checkbox"/> Generic Substitution Permissible		