



Hepatitis C Program Referral

BIOMED Pharmaceuticals

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Corporate Office 1512 8th Ave. Suite 100 Fort Worth, TX 76104	Desoto 2727 Bolton Boone Dr. Ste 110 Desoto, TX 75115	Houston 1919 N. Loop West, Ste 180 Houston, TX 77008	Tyler 837 S. Fleishel Tyler, TX 75701	San Antonio 211 North San Saba, Suite 205 San Antonio, TX 78207
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Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ St. _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Male _____ Female _____

Weight: _____ Allergies: _____ Primary Language _____

Emergency Contact Name _____ Relationship _____ Phone _____

Primary Insurance: _____ Secondary Insurance: _____

Phone #: _____ Subscriber: _____ Phone #: _____ Subscriber: _____

DOB: _____ ID#: _____ Policy/Group #: _____ DOB: _____ ID#: _____ Policy/Group #: _____

Employer: _____ Employer: _____

Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis: 070.54 Hep C Chronic Other _____ Code _____

PEG INTRON REDIPEN and VIALS

___ 50 mcg/0.5 ml **Redipen** SQ Weekly
 ___ 80 mcg/0.5 ml **Redipen** SQ Weekly
 ___ 120 mcg/0.5 ml **Redipen** SQ Weekly
 ___ 150 mcg/0.5 ml **Redipen** SQ Weekly

___ 50 mcg/0.5 ml **Vial** SQ Weekly
 ___ 80 mcg/0.5 ml **Vial** SQ Weekly
 ___ 120 mcg/0.5 ml **Vial** SQ Weekly
 ___ 150 mcg/0.5 ml **Vial** SQ Weekly

Volume per Injection:
 ___ 0.4 ml ___ 0.5 ml Other _____ ml Refill x _____ Months

PEGASYS

___ PEGASYS CONVENIENCE PACK
 #4 180 mcg **Pegasys Prefilled Syringes**
 #4 27 g 1/2 ml syringe with safety needle
 #4 Alcohol Swabs

___ PEGASYS CONVENIENCE PACK
 #4 180 mcg **Pegasys Vials**
 #4 27 g 1/2 ml syringe with safety needle
 #4 Alcohol swabs
 ___ 180 mcg SQ once Weekly #4 Vials

Other: _____

Refill x _____ Months

REBETOL CAPSULE

___ 600 mg po daily; 200 mg QAM, 400 mg QPM
 ___ 800 mg po daily; 400 mg QAM, 400 mg QPM
 ___ 1000 mg po daily; 400 mg QAM, 600 mg QPM
 ___ 1200 mg po daily; 600 mg QAM, 600 mg QPM

Other: _____ Refills x _____ Months

Supplies:

___ 1 ml syringes	# _____	Refills _____
___ 3 ml syringes	# _____	Refills _____
___ 25 g 5/8" needle	# _____	Refills _____
___ 27 g 1/2" needle	# _____	Refills _____
Other: _____	# _____	Refills _____
Other: _____	# _____	Refills _____

RIBAVIRIN

___ 800 mg po daily; 400 mg QAM, 400 mg QPM
 ___ 1000 mg po daily; 400 mg QAM, 600 mg QPM
 ___ 1200 mg po daily; 600 mg QAM, 600 mg QPM

Other: _____ Refills x _____ Months

COPEGUS

___ 800 mg po daily; 400 mg QAM, 400 mg QPM (Genotype 2,3)
 ___ 1000 mg po daily; 400 mg QAM, 600 mg QPM
 (Genotype 1,4 Wt. <75 kg/166 lb)
 ___ 1200 mg po daily; 600 mg QAM, 600 mg QPM
 (Genotype 2,3 Wt. <75 kg/166lb)

Other: _____ Refills x _____ Months

INFERGEN

___ 9 mcg TIW for _____ weeks ___ 15 mcg TIW for _____ weeks
 ___ 9 mcg q day ___ 15 mcg q day

Refills x _____ Months

OTHER: _____
 Refills x _____ Months

Patient Status-to be filled out by pharmacy

No contact as of: _____ PA required: ___yes ___no Ship Date: _____

Generic can be substituted where available _____ Yes _____ No

Physician Certification: Anticipated Start Date: _____ Today's Date _____ DEA # _____ NPI# _____

Signature: _____ Print Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ TPI # _____ UPIN# _____ Tax ID# _____



Please send front and back copies of all insurance cards with referral.