

# HEPATITIS C ENROLLMENT FORM



DATE NEEDED: \_\_\_\_\_ MEDICATION/INJECTION START DATE: \_\_\_\_\_

Phone: 888-282-5166 Fax: 248-282-0471

## Patient Information

Patient Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Patient's Primary Language: \_\_\_\_\_  
Alternate Contact Name: \_\_\_\_\_  
Alternate Contact Phone: \_\_\_\_\_  
Ship to:  Patient  Physician  Other: \_\_\_\_\_

## Patient Insurance Information

Please copy front and back of medical and pharmacy insurance card and fax to Walgreens Specialty Pharmacy with this form  Medicare/Medicaid

**Primary Insurer:** \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
**Secondary Insurer:** \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
Employer: \_\_\_\_\_

## PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Walgreens Specialty Pharmacy to release any and all information it may have as necessary for Walgreens Specialty Pharmacy to (i) establish my eligibility for benefits; (ii) provide to me products, supplies or services; (iii) receive payment of benefits on my behalf; (iv) communicate with other healthcare providers regarding medical care provided, or to be provided, to me; (v) facilitate the provision of products, supplies, services or training required for my treatment through the product manufacturer, which may be used for promotional programs. I understand that my personal health information is subject to redisclosure. I have the right to revoke this authorization in writing at any time. I also have a right to receive a copy of this authorization. My refusal to sign this authorization will have no impact on receiving treatment from Walgreens Specialty Pharmacy. This authorization is valid for the duration of my treatment with Walgreens Specialty Pharmacy unless revoked in writing.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Diagnosis Information

Please copy chart notes medication history and baseline lab results and fax to Walgreens Specialty Pharmacy with prescription

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of weight: \_\_\_\_\_  
Choose one of the following:  Therapy naïve  Relapsing  Non-responder HCV Genotype:  1  2  3  4  Other \_\_\_\_\_  
Choose one of the following:  New  Restart  Currently on Therapy (Start Date: \_\_\_\_\_)  
Other Conditions:  Compensated liver disease  HBV (0.70)  HIV  Cirrhosis  Bridging fibrosis  Steatosis

DATE	White Blood Count (WBC)	Red Blood Count (RBC)	Hemoglobin (HGB)	Neutrophil Count (ANC)	Platelet Count (PLT)	TSH	ALT	AST	Bilirubin

HCV RNA Initial Viral Load: \_\_\_\_\_ IU/ml (Date: \_\_\_\_\_) HCV RNA Viral Load Week 12: \_\_\_\_\_ IU/ml (Date: \_\_\_\_\_)

Allergies: \_\_\_\_\_ Other Medications Currently Taking: \_\_\_\_\_

## Physician Information

Physician Name: \_\_\_\_\_ Site/Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Specialty: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ Office Contact E-Mail: \_\_\_\_\_  
St. Lic. #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
Office Hours: M - F \_\_\_\_\_ Sat: \_\_\_\_\_ Days Closed: \_\_\_\_\_

## Prescription Information

**Pegasys® Prefilled Syringe Kit** (180mcg/0.5ml)  
 **Pegasys® Vials** (180mcg/1ml)  Enroll in PEGASSIST Program  Starter Kit  
**Directions: Inject:** \_\_\_\_\_  
**SQ once weekly:** \_\_\_\_\_ **Qty:** \_\_\_\_\_ **Refill:** x \_\_\_\_\_

**Ribavirin 200mg tablets** [ Brand: Copegus®]  
**Directions:** Take \_\_\_\_\_ po QAM and \_\_\_\_\_ po QPM.  
Take with food. **Qty:** \_\_\_\_\_ **Refill:** x \_\_\_\_\_

**Peg-Intron Redipen®**  **Peg-Intron® Vials** (1.5mcg/kg)  
**Strength:** \_\_\_\_\_ **Qty:** \_\_\_\_\_ **Refill:** x \_\_\_\_\_  
**Directions: Inject** \_\_\_\_\_ mcg ( \_\_\_\_\_ ml) **SQ once weekly**  
 Enroll in *Be in Charge Program*  Send Starter Kit

**Ribavirin 200mg Capsules** [ Brand: Rebetol®]  
**Qty:** \_\_\_\_\_ **Refill:** x \_\_\_\_\_  
**Directions:** Take \_\_\_\_\_ po QAM and \_\_\_\_\_ po QPM. Take with food.

<b>Infergen®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____
<b>Neupogen®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____
<b>Aranesp®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____
<b>Procrit®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____
<b>Epogen®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____
<b>Hepavir®B/Hepsera®</b>	Strength: _____	Qty: _____	Directions: _____	Refill x _____

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Walgreens Specialty Pharmacy will confirm order upon receipt and follow up every 48 - 72 hours with insurance updates. In order for a brand name product to be dispensed, the prescriber must hand write "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space below.

**FOR INTERNAL USE ONLY** Name: \_\_\_\_\_ Ext.: \_\_\_\_\_ Date: \_\_\_\_\_ Code: \_\_\_\_\_

**Peg-Intron / Ribavirin Recommended Doses**

Dosing recommendations for use with Ribavirin:

<u>Weight (lbs)</u>	<u>Strength</u>	<u>Recommended Dose</u>
<input type="checkbox"/> (less than 88 lbs)	50mcg/0.5ml	50mcg (0.5ml) once weekly
<input type="checkbox"/> (88-110 lbs)	80mcg/0.5ml	64mcg (0.4ml) once weekly
<input type="checkbox"/> (111-132 lbs)	80mcg/0.5ml	80mcg (0.5ml) once weekly
<input type="checkbox"/> (133-165 lbs)	120mcg/0.5ml	96mcg (0.4ml) once weekly
<input type="checkbox"/> (166-187 lbs)	120mcg/0.5ml	120mcg (0.5ml) once weekly
<input type="checkbox"/> (greater than 187 lbs)	150mcg/0.5ml	150mcg (0.5ml) once weekly

Total daily dosing recommendations:

<u>Weight (lbs)</u>	<u>Dose</u>	<u>Quantity</u>
<input type="checkbox"/> (less than 88 lbs)	600mg	#84
<input type="checkbox"/> (88-132 lbs)	800mg	#112
<input type="checkbox"/> (133-187 lbs)	1000mg	#140
<input type="checkbox"/> (188-230 lbs)	1200mg	#168
<input type="checkbox"/> (greater than 230 lbs)	1400mg	#196

**Phone: 888.282.5166**

**Fax to 4D for Prior Authorization:**

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