HEPATITIS C

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:		Male/Female:
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete or Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:			
Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity **Date:**

Diagnosis:

☐ 070.54 Hepatitis C (Chronic) ☐ Other:_____

Naïve Patients or New Treatment Starts (Pre-Treatment Labs):

Genotype: ☐1 ☐2 ☐3 ☐4 ☐Other_____ Lab Date: _____ HCV Viral Load: IU/ml_____ or copies/ml_____ Lab Date: _____

Alanine Aminotransferase (ALT):_____ Normal Range: _____ Lab Date: _____

Asparate Aminotransferase (AST):_____ Normal Range: _____ Lab Date: _____

For HIV Co-Infected Members – CD4 Count_____ Lab Date: _____

For HIV Co-Infected Members – RNA Viral Load_____ Lab Date: _____

Liver Biopsy Result or attach copy with request: _____

Continuation of Therapy (Labs after 12 weeks of Therapy):

HCV Viral load: UI/ml_____ or Copies/ml_____ Lab Date: _____

Alanine Aminotransferase (ALT):_____ Normal Range: _____ Lab Date: _____

Asparate Aminotransferase (AST):_____ Normal Range: _____ Lab Date: _____

Pre-Treatment Labs - Labs done before starting therapy:

HCV Viral load: UI/ml_____ or Copies/ml_____

Alanine Aminotransferase (ALT):_____ Normal Range: _____ Lab Date:_____

Prescription

☐ PEGASYS 180mcg ☐ PFS ☐ Vial - Directions: ☐ 180 mcg SQ every week ☐ 90 mcg SQ every week ☐ 135 mcg SQ every week ☐ Other_____

Qty: 28 days supply Refills: _____

☐ PEG-INTRON ☐ 50 mcg/0.5ml ☐ Redipen ☐ Vial - Directions: ☐ 50 mcg (0.5ml) SQ QWK ☐ 96 mcg (0.4ml) SQ QWK
☐ 80 mcg/0.5ml ☐ Redipen ☐ Vial ☐ 64 mcg (0.4ml) SQ QWK ☐ 120 mcg (0.5ml) SQ QWK
☐ 120 mcg/0.5ml ☐ Redipen ☐ Vial ☐ 80 mcg (0.5ml) SQ QWK ☐ 150 mcg (0.4ml) SQ QWK
☐ 150 mcg/0.5ml ☐ Redipen ☐ Vial

Qty: 28 days supply Refills: _____

☐ INFERGEN ☐ 9mcg ☐ 15mcg SQ ☐ Other:_____ Directions: ☐ SQ daily ☐ SQ TIW Qty: _____ Refills: _____

☐ RIBAPAK ☐ 800mg/day ☐ 1000mg/day ☐ 1200mg/day Directions: ☐ 400 mg tab QAM, 400 mg tab QPM
☐ 600 mg tab QAM, 400 mg tab QPM
☐ 1200 mg tab QAM, 600 mg tab QPM

Qty: 28 days supply Refills: _____

☐ COPEGUS ☐ 600mg ☐ 800mg ☐ 1000mg ☐ 1200mg ☐ Other:_____ Directions: ☐ 200 mg QAM, 400 mg QPM ☐ 400 mg QAM, 400 mg QPM ☐ 400 mg QAM, 600 mg QPM ☐ 600 mg QAM, 600 mg QPM

Qty: 28 days supply Refills: _____

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DECILLION HEALTHCARE

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	
Hospital/Clinic:	Phys. Phone:	Phys. Fax:	
Address:	Office Contact:		

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____

All the supplies including syringes and needles will be dispensed if needed.

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient's Signature_____ Date_____

Rev. 07.21.2013