Hepatitis C Referral Form

MedPro Rx™
A DIPLOMAT® COMPANY

Phone: (888) 571-3100 • Fax: (800) 582-9315

Date: _____

Demographics

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Phone: (*home*) _____

(*work*) _____

(*cell*) _____

Social Security Number: _____

Next of Kin: _____

Height: _____ Weight: _____

Insurance Information:

Primary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Secondary Insurance: _____

Member ID #: _____ Group #: _____

Policy Holder: _____ Relationship: _____

Diagnosis:

☐ Hepatitis C ICD-9 Code: _____

Genotype: _____

Allergies: _____

Date of last dose (if applicable): _____

Physician Orders: *(Please check the following)*

☐ Pegasys _____ mcg SQ weekly x _____ weeks

☐ Peg-Intron _____ mcg SQ weekly x _____ weeks

☐ Ribavirin _____ x _____ weeks

☐ _____

☐ Skilled Nursing visits as required for teaching

☐ Teaching to be done by physician office

☐ Standard supplies as requested

Prescribing Physician:

Name: _____

Address *(please include facility name)*:

_____

_____

_____

Phone: _____ Fax: _____

Specialty: _____

License #: _____ UPIN #: _____

DEA #: _____ NPI #: _____

I have read this entire form and verify to its accuracy ☐ Yes

Prescriber Signature: _____
Dispense as written

Prescriber Signature: _____
Substitution allowed

Date: _____

Please CLICK HERE to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)

MedPro Rx, Inc. is compliant with HIPAA Guidelines