

AllCare Pharmacy Inc.,

PATIENT REFERRAL FORM

HEPATITIS-C (ICD Code 070.51)

FAX: 508. 754. 8878

PATIENT INFORMATION (Please complete this part or attach a copy of patient demographic sheet)

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ Allergies: _____

City: _____ State: _____ Zip: _____ Phone #: _____ SEX _____

INSURANCE INFORMATION (May skip if the patient has Masshealth only. Just provide the SSN)

Primary Insurance: _____ Patient ID #: _____

Phone #: _____ Group #: _____

Secondary Insurance: _____ Patient ID #: _____

Phone #: _____ Group #: _____

PRESCRIPTION INFORMATION

Commonly Prescribed Medication

PEGASYS

- Convenience Pak
180mcg/1ml
- Pre-Filled Syringe Conv. Pak
180mcg/0.5ml
- Single Dose Vials.
180mcg/1ml

PEG INTRON

- Redi Pen
 - 50mcg/0.5ml
 - 80mcg/0.5ml
- Vials
 - 120mcg/0.5ml
 - 150mcg/0.5ml

RIBAVARIN

- 200MG, 400MG, 600MG TABS
- ROBETROL 200MG CAPS
- COPEGUS 200MG TABS

RIBA-PAK

- Ribavarin 400mg/400mg tabs
- Ribavarin 600mg/400mg tabs
- Ribavarin 600mg/600mg tabs

AFFIX PRESCRIPTION HERE

PRESCRIBER INFORMATION

Prescriber Name: _____ Tel #: _____

Address: _____ Fax#: _____

City: _____ State: _____ Zip: _____ Date: _____

DATE NEEDED BY: _____

DELIVERY

- TO OFFICE
- TO PATIENT
- OTHER

PRESCRIBERS SIGNATURE: _____

INTERCHANGE IS MANDATED UNLESS THE PROVIDER WRITES THE WORDS " NO SUBSTITUTION" IN THE ABOVE SPACE

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