

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: \_\_\_\_\_

**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

**Insurance Information:**

**Primary Insurance:** \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Prescribing Physician:**

**Name:** \_\_\_\_\_  
**Address** *(please include facility name):*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_  
**License #:** \_\_\_\_\_ **UPIN #:** \_\_\_\_\_  
**DEA #:** \_\_\_\_\_ **NPI #:** \_\_\_\_\_  
**Physician Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Diagnosis:**

Hepatitis C ICD-9 Code: \_\_\_\_\_  
Genotype: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Date of last dose (if applicable): \_\_\_\_\_