

# LINCOLN PHARMACY

831 STERLING PARKWAY, SUITE #120, LINCOLN, CA 95648

PHONE: 916-209-3618 | FAX: 916-209-3634 | [www.yourlincolnpharmacy.com](http://www.yourlincolnpharmacy.com)

Date: \_\_\_\_\_

## HEPATITIS C PRESCRIPTION FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ SSN: \_\_\_\_\_  
Phone: \_\_\_\_\_

Need by Date: \_\_\_\_\_  
Ship to:  Patient Home  
 Other: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Contact Person: \_\_\_\_\_

### DIAGNOSIS/ CLINICAL INFORMATION – Please, provide most recent lab report

ICD-9 Code:  070.54 Hepatitis C Genotype: \_\_\_\_\_  \_\_\_\_\_  ALT: \_\_\_\_\_  AST: \_\_\_\_\_  Viral Load HCV RNA: \_\_\_\_\_  
Weight: \_\_\_\_\_ lbs / kg Allergies: \_\_\_\_\_ Please circle: Naive Patient / Non-Responder / Relapsed Patient

### PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION

PREVIOUSLY DISPENSED

#### MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
<input type="checkbox"/> Incivek®	<input type="checkbox"/> 375mg	<input type="checkbox"/> Take 2 tablets PO TID (7-9 hours apart) ; each dose with 20g fat	168	
<input type="checkbox"/> Victrelis®	<input type="checkbox"/> 200mg	<input type="checkbox"/> Take 4 capsules (800mg) PO TID with food	336	
<input type="checkbox"/> Pegasys® <input type="checkbox"/> PFS <input type="checkbox"/> Pro-click	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 90mcg SQ once weekly <input type="checkbox"/> 180mcg SQ once weekly <input type="checkbox"/> 135mcg SQ once weekly	28 d	
<input type="checkbox"/> Peg-Intron Redipen®	<input type="checkbox"/> <88 lbs: 50mcg/0.5ml: 50mcg SQ once weekly <input type="checkbox"/> 88-110 lbs: 80mcg/0.5ml: 64mcg SQ once weekly <input type="checkbox"/> 112-132 lbs: 80mcg/0.5ml: 80mcg SQ once weekly	<input type="checkbox"/> 134-165 lbs: 120mcg/0.5ml : 96mcg SQ once weekly <input type="checkbox"/> 167-187 lbs: 120mcg/0.5ml : 120mcg SQ once weekly <input type="checkbox"/> >187 lbs: 150mcg/0.5ml : 150mcg SQ once weekly	28 d	
<input type="checkbox"/> Procrit®	<input type="checkbox"/> 20,000 U/ml : 20,000U SQ once weekly <input type="checkbox"/> 30,000 U/ml : 30,000U SQ once weekly <input type="checkbox"/> 40,000 U/ml : 40,000U SQ once weekly		28 d	
<input type="checkbox"/> RibaPak®	<input type="checkbox"/> 600mg dose pack	<input type="checkbox"/> 200mg every AM, 400mg every PM <input type="checkbox"/> 600mg every AM, 400mg every evening <input type="checkbox"/> 400mg every AM, 400mg every PM <input type="checkbox"/> 600mg every AM, 600mg every evening	28 d	
<input type="checkbox"/> Ribarivin (generic)	<input type="checkbox"/> 200mg			

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  Do not substitute

#### Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

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

**Important Notice:** This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.

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Date: \_\_\_\_\_

## HEPATITIS B PRESCRIPTION FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ SSN: \_\_\_\_\_  
Phone: \_\_\_\_\_

Need by Date: \_\_\_\_\_  
Ship to:  Patient Home  
 Other: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Contact Person: \_\_\_\_\_

### DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code:  070.3 Hepatitis B  \_\_\_\_\_  New Therapy  Continued Therapy **Start Date:** \_\_\_\_\_  
ALT: \_\_\_\_\_ HBV DNA (Viral Load) : \_\_\_\_\_ Weight: \_\_\_\_\_ lbs / kg

Most recent Lab date: \_\_\_\_\_  
 HBeAg : + / -  
 HBeAb : + / - (+: reactive/ -: non)  
 HBsAg : + / -

### PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION

PREVIOUSLY DISPENSED

### MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
<input type="checkbox"/> Baraclude®	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1.0 mg	<input type="checkbox"/> Take 1 tablet by mouth daily <input type="checkbox"/> Other: _____	30 d	
<input type="checkbox"/> Epivir HBV®	<input type="checkbox"/> 100mg <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Hepsera®	<input type="checkbox"/> 10mg			
<input type="checkbox"/> Tyzeka®	<input type="checkbox"/> 600 mg			
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300mg			
<input type="checkbox"/> Pegasys® <input type="checkbox"/> PFS <input type="checkbox"/> Pro-click	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 90mcg SQ once weekly <input type="checkbox"/> 180mcg SQ once weekly <input type="checkbox"/> 135mcg SQ once weekly	28 d	
<input type="checkbox"/> HBIG (Hepatitis B Immune Globulin – single use vial)				

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  Do not substitute

### Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

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

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