ADVANCED PHARMACY
& RESPIRATORY CARE
SOLUTIONS

"PERSONALIZED SPECIALTY HEALTHCARE"
26611 CABOT RD.
LAGUNA HILLS, CA 92653

HEPATITIS C REFERRAL

PATIENT INFORMATION		PHYSICIAN INFORMATION	
PATIENT NAME:		PHYSICIAN NAME:	
DOB:	SEX:☐ M ☐ F	LIC#	NPI:
ADDRESS:		ADDRESS:	
CITY/STATE/ZIP		CITY/STATE/ZIP:	
PHONE:		PHONE	FAX:
ALT PHONE:		OFFICE CONTACT :	EXT:

INSURANCE INFORMATION:	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER:	SUBSCRIBER:
ID#:	ID#:
GROUP POLICY:	GROUP POLICY:
PHONE:	PHONE:
EMPLOYER:	EMPLOYER:

PRESCRIPTION:	DOSE/DIRECTIONS:
Pegasys® (peginterferon alpha 2a)	SINGLE-USE VIAL: ☐135MCG/0.5ML PROCLICK SDPF ☐180MCG/0.5 PRE-FILLED SYRINGE ☐180MCG/ML SINGLE DOSE VIAL SIG: _______ ____________________REFILL
Peg-Intron® (peginterferon alpha 2b)	☐ 50MCG/0.5ML PRE-FILLED SYRINGE ☐ 80 MCG/0.5ML PRE-FILLED SYRINGE ☐ 120 MCG/0.5ML PRE-FILLED SYRINGE ☐ 150 MCG/0.5ML PRE-FILLED SYRINGE SIG: ____ Q ____ ___________ REFILLS
Rebetrol® (ribavirin)	☐ 40 MG/ML SIG: _______________ Q ________________ REFILLS____________
Infergen® (interferon alfacon-1)	☐9 MCG/0.3ML SDPF ☐ 15MCG/0.5ML SDPF SIG: _______________ Q ________________ REFILLS____________
Sylatron® (peginterferon alfa-2b)	☐296 MCG KIT ☐ 444 MCG KIT ☐888 MCG KIT SIG: _______________ Q ________________ REFILLS____________
(WRITE IN ADDITIONAL RX)	

DIAGNOSIS/STATEMENT OF MEDICAL NECESSITY: (PLEASE INCLUDE ALL RELEVANT DOCUMENTATION WHEN FAXING)

SIGNATURE: ___________________________ DATE: ______________________

FAX TO 949-582-6111