

Please indicate if you have a  
**Preferred Specialty Pharmacy:**

### PATIENT INFORMATION

Patient name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
 Language: \_\_\_ English \_\_\_ Spanish \_\_\_ Other: \_\_\_\_\_  
 Parent/guardian (if applicable): \_\_\_\_\_  
 Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_  
 Alternate contact #: \_\_\_\_\_  
 Street address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber name: \_\_\_\_\_  
 Office contact: \_\_\_\_\_  
 Practice name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ DEA No.: \_\_\_\_\_  
 Physician Medicaid UPIN No.: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance company name: \_\_\_\_\_  
 Insurance company phone #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy holder's name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Prescription card: \_\_\_ No \_\_\_ Yes If yes, carrier \_\_\_\_\_  
 ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

### DELIVERY INFORMATION

Date medication needed: \_\_\_\_\_  
 Ship drug to: \_\_\_ Physician's office \_\_\_ Patient's home  
 (If shipped to physician's office, physician accepts on behalf of patient for administration in office.)

### CERTIFICATION OF MEDICAL NECESSITY; AUTHORIZATION FOR ASPIRE TO ACT ON MY BEHALF

I certify that the drug therapy listed above is necessary for the above named patient. Submission of this form and my signature below authorizes Proherant Health, Inc. d/b/a Aspire® Patient Support Program (Aspire®) to investigate and confirm the named patient's prescription drug insurance coverage for the specified drugs. If the patient's insurance requires prior authorization, Aspire® is authorized to pursue the prior authorization process on my behalf. If the patient's insurance denies coverage, Aspire® is authorized to pursue the appeal on my behalf. Upon confirmation of insurance coverage, Aspire® is authorized to forward the prescription contained herein to the specialty pharmacy designated above or to another authorized pharmacy if none is specified.

**Prescriber's Signature (No Stamps):**

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

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### DIAGNOSIS and CLINICAL INFORMATION

Diagnosis/ ICD-9 Code: \_\_\_\_\_ Hepatitis C - 070.54 Other: \_\_\_\_\_  
 HCV genotype: 1 2 3 4 5 6 (Please circle)

If applicable, dates of previous interferon/ribavirin therapy: \_\_\_\_\_

If applicable, name of previous interferon/ribavirin therapy: \_\_\_\_\_

If applicable, response to previous therapy: \_\_\_ Non-responder \_\_\_ Relapser

Other: \_\_\_\_\_

Liver biopsy: Date \_\_\_\_\_ Grade \_\_\_\_\_ Stage \_\_\_\_\_

Steatosis?: Y or N

Comorbidities: \_\_\_\_\_

Current weight: \_\_\_\_\_ kg/lbs (Please circle)

Date weight recorded: \_\_\_\_\_

\_\_\_ NKDA \_\_\_ Allergies \_\_\_\_\_

### Drug: Ribasphere® RibaPak® (ribavirin, USP)

Strength: \_\_\_ 400mg - 400mg tablets 28 days supply  
 \_\_\_ 400mg - 600mg tablets 28 days supply  
 \_\_\_ 600mg - 600mg tablets 28 days supply

QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

Directions: \_\_\_\_\_

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

**Prescriber's Signature:** \_\_\_\_\_

**Dispense As Written.**

**Signature Required. NO STAMPS PLEASE.**

### Drug: Ribasphere® (ribavirin, USP) 200 mg Tablets

Strength: 200 mg tablets Frequency: \_\_\_\_\_

QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

Directions: \_\_\_\_\_

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

**Prescriber's Signature:** \_\_\_\_\_

**Dispense As Written.**

**Signature Required. NO STAMPS PLEASE.**

### Drug: INFERGEN® (Interferon alfacon - 1)\*

Strength: \_\_\_ 9mcg \_\_\_ 15mcg Frequency: \_\_\_\_\_

QTY: \_\_\_\_\_ Refill: \_\_\_\_\_

Directions: \_\_\_\_\_

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

**Prescriber's Signature:** \_\_\_\_\_

**Dispense As Written.**

**Signature Required. NO STAMPS PLEASE.**

\* Prescription to include all necessary ancillary supplies (i.e. needles, syringes)

### PATIENT CONSENT and HIPAA AUTHORIZATION

I acknowledge that Kadmon Pharmaceuticals, LLC, the maker of Ribasphere® and Infergen®, sponsors the Aspire® Patient Support Program, managed by its agent, but does not receive any of my health and personal information. I authorize the Aspire® Patient Support Program to contact my healthcare provider, pharmacy, insurance company and any third-party payors, to release and disclose to such parties all relevant medical records, insurance and third party payor information to facilitate reimbursement for the prescribed medicines, and to send my prescription(s) to the specialty pharmacy named above, or to another authorized pharmacy if none is specified, to facilitate dispensing of the prescribed medicines to me. I also authorize my health care provider, pharmacy, insurance company and any third-party payors, to release and disclose to the Aspire® Patient Support Program such of my health and personal information as is necessary to fulfill the above purposes. I also authorize the Aspire® Patient Support Program to send me educational materials concerning my prescribed medicines and treatment and to contact me about patient support programs.

This authorization will expire in five (5) years. I understand that my participation in the Aspire® Patient Support Program and related programs is entirely voluntary and I can withdraw my participation and/or revoke this authorization at any time by notifying the Aspire® Patient Support Program by fax at the number shown at the top of this form. I also understand that, if I do not sign this authorization or if I revoke it, my healthcare provider will still treat me for my condition and I will still be eligible to receive the medicines prescribed for me; however, I will not be eligible for enrollment in the Aspire® Patient Support Program and I will not receive the patient support services provided by the program.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_