



Hepatitis B Prescription Referral Form

Send your Rx to: _____

If you need a medication not listed,
please contact us.

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD-10: _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Baraclude®	0.5mg 1mg 0.05mg/ml:	0.5mg tab by mouth daily 1mg tab by mouth daily Other:	30 ml	
Epivir HBV	100mg	100mg by mouth daily	30	
Hepsera®	10mg	10mg by mouth daily	30	
HBIG (Hepatitis B Immune Globulin - single use vial)				
Pegasys® Prefilled Syringe Vial ProClick®	180mcg 135mcg	180 mcg SQ once weekly 135 mcg SQ once weekly 90 mcg SQ once weekly	28 day supply	
Tyzeka®	600mg	600mg by mouth daily	30	
Vemlidy®	25mg	25mg by mouth daily with food	30	
Viread®	300mg	300mg by mouth daily Other:	30	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____

Date: _____

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissible

Date

Dispense as written

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____