Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

HEPATITIS B REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑Hepatitis B ❑HIV-HBV Co-infection ❑Other: _____

Medical Assessment: Please provide the information below of fax copies of labs to above number.

PCR for HBV DNA (Viral Load)_____, Date:_____AST/ALT _____CrCl_____

Ratio_____/_____Date:_____❑ e-antigen + (HBeAg+)/❑ e-antigen – (HBeAg-),

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Baraclude**		
❑0.5 mg tab: Take 1 tablet PO daily on empty stomach (Naïve PT)	QTY: 30 Tabs	Refills:_____
❑1 mg tab: Take 1 tablet PO daily on empty stomach (Lamivudine-Refractory or decompensated liver disease)	QTY: 30 Tabs	Refills:_____
❑0.05 mg/mL oral solution: _____	QTY: _____	Refills:_____
❑Alternate Dose (CrCL<50 mL/min or Dialysis): _____	QTY: _____	Refills:_____
❑**Epivir HBV 100 mg**		
❑100 mg PO daily	QTY: 30 Tabs	Refills:_____
❑**Epivir HBV 150 mg**		
❑150 mg PO BID (only for co-infected PT with HIV)	QTY: 60 Tabs	Refills:_____
❑ **Epivir HBV 5mg/ml oral solution**: _____	QTY: _____	Refills:_____
❑ Alternate Dose (CrCL<50 mL/min or Dialysis): _____	QTY: _____	Refills:_____
❑**HBIG** *Hepatitis B Immune Globulin-single use vial, greater than 1560 International Units/5 mL, greater than 312 International Units/mL*		
❑5 mL IM in 2 divided doses ❑Once or ❑every 28 days.	QTY: 5 mL vial	Refills:_____
❑2 mL IM in 2 divided doses ❑Once or ❑every 28 days.	QTY: 2 of 1 mL vial	Refills:_____
❑ **HBIG MD Infusion (1560 International Units/5ml vials)**		
❑20,000 International Units (64mL) in 250 mL NS, IV over _____ hour(s), every _____ for _____ infusions	QTY: _____ Vials	Refills:_____
❑Alternate Dose: _____	QTY:_____ Vials	Refills:_____
❑**Hepsera 10 mg**		
❑10 mg PO daily	QTY: 30 Tabs	Refills:_____
❑Alternate Dose (CrCL<50 mL/min or Dialysis): _____	QTY: _____	Refills:_____
❑**Pegasys 180 mcg Prefilled Syringe (OR)** ❑**Pegasys 180 mcg Vial** **Will dispense prefilled syringe unless vial is marked*		
❑180 mcg SQ once every week	QTY: 28 days	Refills:_____
❑ Alternate Dose (CrCL<50 mL/min or Dialysis): _____	QTY: _____	Refills:_____
❑**Vemlidy 25 mg**	QTY: 30 Tabs	Refills:_____
❑25 mg PO daily with food	QTY: 30 Tabs	Refills:_____
❑**Viread 300 mg**		
❑300 mg PO daily	QTY: 30 Tabs	Refills:_____
❑ Alternate Dose (CrCL<50 mL/min or Dialysis): _____	QTY: _____	Refills:_____
❑**Other:** _____	QTY: _____	Refills:_____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

3.9.20

An envolve Pharmacy Solution

Phone: 800.511.5144 ● Fax: 877.541.1503