

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: <input type="checkbox"/> M <input type="checkbox"/> F Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:	
Address:		City:	State: Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> 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 ASSESSMENT			
<b>Primary Diagnosis:</b> <input type="checkbox"/> Hepatitis B <input type="checkbox"/> HIV-HBV Co-infection <input type="checkbox"/> Other: _____			
<b>Medical Assessment:</b> 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: _____ <input type="checkbox"/> e-antigen + (HBeAg+) / <input type="checkbox"/> e-antigen - (HBeAg-),			
<ul style="list-style-type: none"> <li>■ Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____</li> <li>■ Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____</li> <li>■ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____</li> <li>■ How long should patient wait before starting the new medication? _____</li> <li>■ Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____</li> </ul>			
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> <b>Baraclude</b>			
<input type="checkbox"/> 0.5 mg tab: Take 1 tablet PO daily on empty stomach (Naive PT)		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> 1 mg tab: Take 1 tablet PO daily on empty stomach (Lamivudine-Refractory or decompensated liver disease)		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> 0.05 mg/mL oral solution: _____		QTY: _____	Refills: _____
<input type="checkbox"/> Alternate Dose (CrCL<50 mL/min or Dialysis): _____		QTY: _____	Refills: _____
<input type="checkbox"/> <b>Epivir HBV 100 mg</b>			
<input type="checkbox"/> 100 mg PO daily		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> <b>Epivir HBV 150 mg</b>			
<input type="checkbox"/> 150 mg PO BID (only for co-infected PT with HIV)		QTY: <u>60 Tabs</u>	Refills: _____
<input type="checkbox"/> <b>Epivir HBV 5mg/ml oral solution:</b> _____		QTY: _____	Refills: _____
<input type="checkbox"/> Alternate Dose (CrCL<50 mL/min or Dialysis): _____		QTY: _____	Refills: _____
<input type="checkbox"/> <b>HBIG Hepatitis B Immune Globulin-single use vial, greater than 1560 International Units/5 mL, greater than 312 International Units/mL</b>			
<input type="checkbox"/> 5 mL IM in 2 divided doses <input type="checkbox"/> Once or <input type="checkbox"/> every 28 days.		QTY: <u>5 mL vial</u>	Refills: _____
<input type="checkbox"/> 2 mL IM in 2 divided doses <input type="checkbox"/> Once or <input type="checkbox"/> every 28 days.		QTY: <u>2 of 1 mL vial</u>	Refills: _____
<input type="checkbox"/> <b>HBIG MD Infusion (1560 International Units/5ml vials)</b>			
<input type="checkbox"/> 20,000 International Units (64mL) in 250 mL NS, IV over _____ hour(s), every _____ for _____ infusions		QTY: _____ Vials	Refills: _____
<input type="checkbox"/> Alternate Dose: _____		QTY: _____ Vials	Refills: _____
<input type="checkbox"/> <b>Hepsera 10 mg</b>			
<input type="checkbox"/> 10 mg PO daily		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> Alternate Dose (CrCL<50 mL/min or Dialysis): _____		QTY: _____	Refills: _____
<input type="checkbox"/> <b>Pegasys 180 mcg Prefilled Syringe (OR) <input type="checkbox"/> Pegasys 180 mcg Vial *Will dispense prefilled syringe unless vial is marked</b>			
<input type="checkbox"/> 180 mcg SQ once every week		QTY: <u>28 days</u>	Refills: _____
<input type="checkbox"/> Alternate Dose (CrCL<50 mL/min or Dialysis): _____		QTY: _____	Refills: _____
<input type="checkbox"/> <b>Vemlidy 25 mg</b>			
<input type="checkbox"/> 25 mg PO daily with food		QTY: <u>30 Tabs</u>	Refills: _____
		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> <b>Viread 300 mg</b>			
<input type="checkbox"/> 300 mg PO daily		QTY: <u>30 Tabs</u>	Refills: _____
<input type="checkbox"/> Alternate Dose (CrCL<50 mL/min or Dialysis): _____		QTY: _____	Refills: _____
<input type="checkbox"/> <b>Other:</b> _____			
		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.

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