Date Shipment Needed: _____ Ship To: ❑Patient ❑Physician; ❑ 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**		

INSURANCE INFORMATION

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

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 or Fax copies of labs to Fax number provided above.)*

PCR for HBV DNA (Viral Load)_____ copies/ml Date:_____AST/ALT _____CrCl

Ratio_____/_____Date:_____ ❑ e-antigen + (HBeAg+) / ❑ e-antigen – (HBeAg-) Co-infected with HIV: ❑ Yes ❑ No

- 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, what is the wash out period? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

PRESCRIPTION INFORMATION

MEDICATION	SIG	QTY	REFILL
❑**Vemlidy 25 mg**	❑25 mg po daily with food	30	
❑**Viread 300 mg**	❑300 mg po daily	30	
	❑Dose adjustment by Creatinine Clearance (if less than 50 ml/min):		
❑**Baraclude**	❑0.5 mg tab po daily (Naïve pt or adolescents ≥ 16 yo)	30	
	❑ 1 mg tab po daily (Lamivudine –Refractory pt)	30	
	❑0.05 mg/ml	_____ml	
	❑ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	30	
❑**Hepsera 10 mg**	❑10 mg po daily	30	
	❑ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):		
❑**Epivir HBV 100 mg**	❑100 mg po daily	30	
❑**Epivir 150 mg**	❑150 mg po BID (only for co-infected pt with HIV)	60	
❑**Tyzeka 600 mg**	❑600 mg po daily	30	
	❑ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	30	
❑**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, every	5 ml vial	
	❑2 ml IM in 2 divided doses, every	2 of 1 ml vial	
	❑10,000 International Units(32 ml) in 250 ml NS, IV over _____hour(s), every_____for_____infusions	_____of 5 ml vials	
	❑Infusion @ MD's office ❑Home infusion *(will fax you" AcariaHealth HBIG Home Infusion Protocol" to be Signed by physician)*		
	❑Alt. Dosage:		
❑**Pegasys** 180 mcg	❑PFS (pre-filled syringes) ❑Vial "Will dispense PFS (prefilled syringe) unless VIAL is marked"		
	❑180 mcg SQ QWK ❑Alternative dosage	28 days	
❑**Epipen** 0.3 mg IMx1,may repeat ❑Epipen Jr for Peds less than 30 kg, 0.15 mg IMx1,may repeat			
❑**Other**			

No written prescription form (including faxed prescriptions) may include more than one prescription. Select only ONE drug per referral form.

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. 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.

Phone: (800) 511-5144 ● Fax: (877) 541-1503