

**HEPATITIS B REFERRAL FORM**

3100 MacCorkle Avenue S.E. | Suite 100  
Charleston, WV 25304  
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

**CURRENT PATIENT**  
 **NEW PATIENT**

Feb 2018

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female  
Street Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BSA \_\_\_\_\_  
Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office  Local Pharmacy Phone \_\_\_\_\_  
Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_  
Current Medications (if necessary, please fax a complete list) \_\_\_\_\_

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION
_____	_____	_____	_____
_____	_____	_____	_____

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Eligible for Medicare  Yes  No If yes, Medicare# \_\_\_\_\_ Prescription Card  Yes  No If Yes, Carrier \_\_\_\_\_  
Tel \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
Bin# \_\_\_\_\_ Pcn# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

ICD-10 Diagnosis Code  \_\_\_\_\_ Diagnosis \_\_\_\_\_ Weight \_\_\_\_\_

Testing?  Yes  No Results \_\_\_\_\_

Patient currently on therapy?  Yes  No Date of next blood work \_\_\_\_\_

**PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS**

**BARACLUDE**  
 0.5mg tablet  1 mg tablet  0.05mg/ml  
SIG:  0.5mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_  
  
SIG:  1mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_  
  
SIG:  Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ml Refills: \_\_\_\_\_

**PEGASYS**  
 **ProClick** 180mcg Autoinjector (NDC 004-0365-30)  
Inject SQ weekly  
 **Pre-Filled Syringe** 180mcg/0.5ml (NDC 004-0357-30)  
Inject SQ weekly  
 Other \_\_\_\_\_  
QTY:  1 month  3 month Refills: \_\_\_\_\_

**TYZEKA**  600mg tablet  
SIG:  600mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_

**EPIVIR HBV**  100mg tablet  5mg/ml  
SIG:  100mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_  
  
SIG:  Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ml Refills: \_\_\_\_\_

**VEMLIDY**  25mg tablet  
SIG:  Take one tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_

**VIREAD**  300mg tablet  
SIG:  300mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_  
  
SIG:  Other: \_\_\_\_\_  
QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

**HEPSERA**  10mg tablet  
SIG:  10mg tablet by mouth daily  
QTY: 30 Refills: \_\_\_\_\_

**HGIB** (Hepatitis B Immune Globulin - single use vial)  
SIG:  \_\_\_\_\_  
QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

**OTHER** \_\_\_\_\_  
Sig \_\_\_\_\_  
Qty \_\_\_\_\_ Refills \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.  
**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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