

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

July 2017

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: _____

HEPSERA 10mg tablet
 SIG: 10mg tablet by mouth daily
 QTY: 30 Refills: _____

SIG: Other: _____
 QTY: _____ 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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