

## HEPATITIS B REFERRAL FORM

*Please fax to Hawaii Specialty Pharmacy at 808-333-3682*

PATIENT INFORMATION:	PHYSICIAN INFORMATION: Ship to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home
Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____	Phone: _____ Fax: _____
Email: _____	Office Email: _____
Soc. Sec #: _____	Key Office Contact: _____
Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	State LIC # _____ NPI # _____ DEA# _____
Weight: <input type="checkbox"/> lbs <input type="checkbox"/> Kg Height: <input type="checkbox"/> ft <input type="checkbox"/> cm BSA: _____	

INSURANCE INFORMATION: <input type="checkbox"/> DEMOGRAPHIC SHEET <input type="checkbox"/> UNIVERSAL CLAIM FORM <input type="checkbox"/> INSURANCE CARDS (front + back)
<i>*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)</i>
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization
Diagnosis / ICD-10: _____
HBsAg: + / - _____ (since: _____ )
Moderate to severe active necroinflammation: Y / N
<input type="checkbox"/> Patient is currently on therapy (Start date: _____ )

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: \_\_\_\_\_

MEDICATIONS AND DIRECTIONS			
Prescription	Directions	Quantity	Refill
<input type="checkbox"/> <b>Hepsera®</b> (adefovir dipivoxil)	<input type="checkbox"/> Take 10 mg by mouth once daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 X 10 mg tablets <input type="checkbox"/> _____	_____
<input type="checkbox"/> <b>Baraclude®</b> (entecavir)	<input type="checkbox"/> Take 0.5 mg by mouth once daily on an empty stomach <input type="checkbox"/> Take 1 mg by mouth once daily on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 30 X 0.5 mg tablets <input type="checkbox"/> 30 X 1 mg tablets <input type="checkbox"/> _____	_____
<input type="checkbox"/> <b>Epivir-HBV®</b> (lamivudine)	<input type="checkbox"/> Take 100 mg by mouth once daily	<input type="checkbox"/> 30 X 100 mg tablets	_____
<input type="checkbox"/> <b>Viread®</b> (tenofovir disoproxil fumarate)	<input type="checkbox"/> Take 300 mg by mouth once daily	<input type="checkbox"/> 30 X 300 mg tablets	_____
<input type="checkbox"/> <b>Vemlidy®</b> (tenofovir alafenamide)	<input type="checkbox"/> Take 25 mg by mouth once daily with food	<input type="checkbox"/> 30 X 25 mg tablets	_____
<input type="checkbox"/> <b>Other</b>		<input type="checkbox"/> 30 day supply	_____

Prescriber Signature Required	*Prescription is void if the number of drugs prescribed is not noted
I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.	
PRESCRIBER SIGNATURE	DATE
NO. OF DRUGS PRESCRIBED _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
<small>Legal Notice: This fax transmission may contain confidential information belonging to the sender which is legally privileged. This information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this faxed information is strictly prohibited. Please notify us by phone to arrange for the return of the original documents. This prescription may be filled at a pharmacy of the patient's choice</small>	