

Date: ____/____/____ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office

HEPATITIS B REFERRAL FORM

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

DIAGNOSIS

B 18.1 Hepatitis B

Other _____

Other _____

Other _____

Other _____

B 18.2 Hepatitis C

B 20 HIV / Aids

Other _____

Other _____

Other _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<input type="checkbox"/> Baraclude*	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 0.05mg/ml:	<input type="checkbox"/> 0.5mg tab by mouth daily <input type="checkbox"/> 1mg tab by mouth daily <input type="checkbox"/> Other: _____	30 <input type="text"/> ml	
<input type="checkbox"/> Epivir HBV	<input type="checkbox"/> 100mg	<input type="checkbox"/> 100mg by mouth daily	30 <input type="text"/>	
<input type="checkbox"/> Hepsera*	<input type="checkbox"/> 10mg	<input type="checkbox"/> 10mg by mouth daily	30 <input type="text"/>	
<input type="checkbox"/> HBIG (Hepatitis B Immune Globulin - single use vial)				
<input type="checkbox"/> Pegasys* <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> ProClick*	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 180 mcg SQ once weekly <input type="checkbox"/> 90 mcg SQ once weekly <input type="checkbox"/> 135 mcg SQ once weekly	28 day supply	
<input type="checkbox"/> Tyzeka*	<input type="checkbox"/> 600mg	<input type="checkbox"/> 600mg by mouth daily	30	
<input type="checkbox"/> Vemlidy*	<input type="checkbox"/> 25mg	<input type="checkbox"/> 25mg by mouth daily with food	30	
<input type="checkbox"/> Viread*	<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg by mouth daily <input type="checkbox"/> Other: _____	30	
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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