

Hepatitis B Referral Form



Phone: 808-533-8887
 Fax: 808-533-1888
 E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: Patient Physician

Patient	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

Provider	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____
	* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info	Current medications (if necessary, please fax copy of complete list): _____
	Diagnosis/ICD-10: B16.2 Hepatitis B B16.9 Hepatitis Other: _____
	Previously treated with interferon? (<input type="checkbox"/> Y <input type="checkbox"/> N) Pre-treatment HBV viral load: _____ Date: _____
	Start date of hep B therapy: _____ ANC: _____ /mm ³ Date: _____
	Pre-treatment ALT: _____ Date: _____ Liver biopsy: (<input type="checkbox"/> Y / <input type="checkbox"/> N) results: _____ Date: _____
	Most recent ALT: _____ Date: _____ Hgb: _____ g/dL Date: _____

Prescription

Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Baraclude®	0.5 mg/1 mg	Take 1 tablet by mouth once daily	30 days supply	
<input type="checkbox"/> Epivir HBV®	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 5 mg/ml oral solution	Take 1 tablet by mouth once daily _____	30 days supply	
<input type="checkbox"/> Hepsera®	10 mg	Take 1 tablet by mouth once daily	30 days supply	
<input type="checkbox"/> Tyzeka®	600mg	Take 1 tablet by mouth once daily	30 days supply	
<input type="checkbox"/> Viread®	300mg	Take 1 tablet by mouth once daily	30 days supply	
<input type="checkbox"/> Other				

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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