benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

HEPATITIS B REFERRAL FORM

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Medicaid ID # _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____

Policy # _____ Group _____

Insurance Phone _____

Secondary Insurance (if applicable) _____

Policy # _____ Group _____

Insurance Phone _____

Prescription Drug Coverage: Company _____ Phone _____

RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ B19.10 Chronic Hepatitis B without hepatic coma ☐ Other _____ Diagnosis date: _____

Pertinent HBV serologies/labs _____

Previous Treatment (Regimen/Duration:) _____

Co-infection? ☐ HCV ☐ HIV If applicable, please send all clinical information pertinent to the patient's co-infection. Scr _____ Date _____ Pregnancy Test ☐ No ☐ Yes ☐ N/A

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE	DIRECTIONS FOR USE	QTY.	REFILLS
☐ Baraclude	☐ 0.5 mg tablet ☐ 1 mg tablet ☐ 0.05 mg/mL oral suspension	☐ Take 0.5 mg daily on an empty stomach. Should be taken at least 2 hours after a meal and 2 hours before the next meal. ☐ Take 1 mg daily on an empty stomach. Should be taken at least 2 hours after a meal and 2 hours before the next meal. ☐ _____ Should be taken at least 2 hours after a meal and 2 hours before the next meal. **** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.*	30 day supply	
☐ Epivir HBV	☐ 100 mg tablet ☐ 5 mg/mL oral solution	☐ Take 100 mg daily with or without food. ☐ _____ **** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.*	30 day supply	
☐ Viread	☐ 300mg tablet ☐ 250mg tablet ☐ 200mg tablet ☐ 150mg tablet ☐ 40mg/gm oral powder	☐ Take 300 mg daily with or without food. ☐ _____ **** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.*	30 day supply	

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere 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 _____