

## 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 \_\_\_\_\_ Secondary Insurance (if applicable) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_ Group \_\_\_\_\_  
 Insurance Phone \_\_\_\_\_ 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
<input type="checkbox"/> Baraclude	<input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 0.05 mg/mL oral suspension	<input type="checkbox"/> Take (1) one tablet daily on an empty stomach. Should be taken at least 2 hours after a meal and 2 hours before the next meal.  <input type="checkbox"/> _____ Should be taken at least 2 hours after a meal and 2 hours before the next meal.  <i>*** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.</i>		
<input type="checkbox"/> EpiVir HBV	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 5 mg/mL oral solution	<input type="checkbox"/> Take 100 mg daily with or without food. <input type="checkbox"/> _____  <i>*** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.</i>		
<input type="checkbox"/> Hepsera®	<input type="checkbox"/> 10 mg tablet	<input type="checkbox"/> Take 1 tablet daily with or without food  <i>*** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.</i>		
<input type="checkbox"/> Vemlidy®	<input type="checkbox"/> 25 mg tablet	<input type="checkbox"/> Take 1 tablet daily with food		
<input type="checkbox"/> Viread	<input type="checkbox"/> 300mg tablet <input type="checkbox"/> 250mg tablet <input type="checkbox"/> 200mg tablet <input type="checkbox"/> 150mg tablet <input type="checkbox"/> 40mg/gm oral powder	<input type="checkbox"/> Take 300 mg daily with or without food. <input type="checkbox"/> _____  <i>*** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.</i>		

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 its 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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