benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017

O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560

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 _____ Secondary Insurance (if applicable) _____

Insurance Phone _____ Insurance Phone _____

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 (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. ☐ _____ 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.*		
☐ 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.*		
☐ Hepsera®	☐ 10 mg tablet	☐ Take 1 tablet daily with or without food **** Dose must be adjusted for renal function. Please provide current Scr and laboratory date.*		
☐ Vemlidy®	☐ 25 mg tablet	☐ Take 1 tablet daily with food		
☐ 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.*		

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

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____