Hepatitis B Referral Form

Fax Referrals To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Phone: (718) 880-1783

Patient Information

Patient: ______________________________ male female DOB: __________ SS#: ______________
last name, first name

Address: ____
street city state zip

Primary phone number: ______________ cell Alternate phone number: ______________ cell

Caregiver: ______________________ Allergies: ______________ NKDA

Comorbidities: ______________ Height:________ Weight: __________ lbs kg Date: ______________

Clinical Information

Current medications (if necessary, please fax copy of complete list): ______________________

Diagnosis/ICD-10: B18.0 Hepatitis B (with delta agent) B18.1 Hepatitis B (without delta agent) other:______________

Previously treated with interferon? (Y / N)

Start date of hep B therapy: ______________

Pre-treatment ALT:______________ Date:__________

Most recent ALT: ______________ Date:__________

Pre-treatment HBV viral load: ____________ Date:__________

ANC:______________ /mm^3 Date:__________

Liver biopsy: (Y / N) results: ____________ Date:__________

Hgb: ______________ g/dL Date:__________

Prescription	Strength	Directions	Quantity	Refills
Hepsera®	10 mg	Take 1 tablet by mouth once daily	30	
Baraclude®	0.5 mg 1 mg	Take 1 tablet by mouth once daily	30	
Tyzeka®	600 mg	Take 1 tablet by mouth once daily	30	
Epivir-HBV®	100 mg	Take 1 tablet by mouth once daily	30	
Vemlidy®	**25** mg	Take 1 tablet by mouth once daily	30	
Viread®	300 mg	Take 1 tablet by mouth once daily	30	

Prescriber + Shipping Information

Prescriber (print): ______________________ Office contact: ______________

Preferred method of contact: Phone Fax Email Preferred contact persons email: ______________

Ship to: Patient Office Alternate ______________________________
shipping address: street city state zip

Office address: ______________________________
(street, suite, city, state, zip)

Phone: ____________ Fax: ____________ NPI: ____________ DEA: ____________

Prescriber's signature: ______________________ Date: ____________

I authorize Nzone Pharmacy, LLC. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Nzone Pharmacy, LLC.

Insurance Information: Please fax copy of insurance card (front + back)

CONFIDENTIALITY NOTICE: This fax is for use only by the person named above. It is private. It may be subject to HIPAA Privacy and security rules. You may not use, copy or share this fax without permission. Please call us at (877) 577-1447 if you received this fax by mistake. Do not destroy this fax until you have spoken with us. We may ask you to destroy or return the fax to us. Thank you for your cooperation. Nzone Pharmacy, LLC DBA Elite Specialty Pharmacy.

Updated on **9/2017**