STAR CARE PHARMACY

"The First Wealth is Health"

175-20 Hillside Avenue • Jamaica, NY 11432
Tel: 718-262-8789 • Fax: 718-262-9083
Toll Free: 888-216-STAR (7827)

HEPATITIS B REFERRAL FORM

Date: ____________ Attn: ______________

Ship to ❐ Patient ❐ Physician ❐ Office Nurse/Training

Patient Information

Patient name: ______________________ DOB: ____________

Sex: ☐ Female ☐ Male SSN: ______________________

Language: ____________ Wt: _____ ☐kg ☐lbs Ht: _____☐cm ☐in

Address: ______________________________

Apt/Suite:______ City: ______________ State: _____ Zip:_______

Phone:__________________ Alternate: ________________

Caregiver name: __________________ Relation:__________

Local pharmacy: ____________________ Phone: __________

Insurance plan: _________________Plan ID:______________

Please fax a copy of front and back of the insurance card (s).

Prescriber + Shipping Information

Prescriber name: ______________________________

NPI: ______________________________

Address: ______________________________

Apt/Suite: _______ City: ____________ State: _______ Zip: ______

Contact: ______________________________

Phone: __________________ Alternate: ______________

Fax:______________________________

Email: ______________________________

If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ B18.0 Hepatitis B (with delta agent) ☐ B18.1 Hepatitis B (without delta agent) ☐Other: ____________________

Pre-treatment HBV viral load: ________________ **Date:** ________________

ANC: ________________/mm³ **Date:** ________________ **Hgb:** ________________g/dL **Date:** ________________

Liver Biopsy: ☐ Yes ☐ No **Biopsy Results:** ______________________________ **Date:** ________________

Pre-treatment ALT: ______________ **Date:** ______________ **Most recent ALT:** ______________ **Date:** ______________

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Comorbidities: ______________________________

Concomitant Medications: ______________________________

Allergies: ☐NKDA ☐ Other: ______________________________

Prescription

Prescription		Quantity	Refill
☐ **Hepsera®** **(adefovir dipivoxil)**	☐ Take 10 mg by mouth once daily ☐ ____________________	☐ 30 x 10 mg tablets ☐ ____________	_____
☐ **Baraclude®** **(entecavir)**	☐ Take 0.5 mg by mouth once daily on an empty stomach ☐ Take 1 mg by mouth once daily on an empty stomach ☐ ____________________	☐ 30 x 0.5 mg tablets ☐ 30 x 1 mg tablets ☐ ____________	_____
☐ **Tyzeka®** **(telbivudine)**	☐ Take 600 mg by mouth once daily	☐ 30 x 600 mg ☐ ____________	_____
☐ **Epivir-HBV®** **(lamivudine)**	☐ Take 100 mg by mouth once daily	☐ 30 x 100 mg tablets	_____
☐ **Viread®** **(tenofovir disoproxil fumarate)**	☐ Take 300 mg by mouth once daily	☐ 30 x 300 mg tablets	_____
☐ **Vemlidy®** **(tenofovir alafenamide)**	☐ Take 25 mg by mouth once daily with food	☐ 30 x 25 mg tablets	_____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ____________________

Stamp signature not allowed, physician signature required.

Prescriber's Signature:______________________________ Date: ____________

I authorize Star Care Pharmacy 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 Star Care Pharmacy.

IMPORTANT NOTICE: This Facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, priviledged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addresee, except by express authority of the sender to the named addressees.