HEPATITIS B PATIENT REFERRAL FORM

Therapy Start Date: _____/_____/__________ Ship To: ☐ Patient ☐ Physician 1st Fill ☐ Physician All Orders ☐ In-store Pickup

Patient Information: *Please attach FRONT and BACK copies of ALL insurance cards.*

Patient Name:______________________________________ Date of Birth: _____/_____/___________ Sex: ☐Male ☐Female

Social Security #: ____________________ Primary Phone: (____) ______-__________ Secondary Phone: (____) ______-__________

Address: ____ City: __________________ State: _____ Zip: __________

Physician Information:

Physician Name: _______________________________ DEA#: _____________ NPI#: ____________ Tax ID#: _________________

Address: ____ City: _________________ State: ______ Zip: __________

Phone: (_____) _______-_________ Fax: (_____) _______-_____________ Key Contact: _______________________________

Diagnostic Information: *Please attach recent Labs, Tests, and Clinical Notes.*

◆Current medications (If necessary, please fax copy of complete list):____

◆ICD-10: ☐B18.0 Hepatitis B ☐B18.1 Hepatitis B ◆Other:_____________________________

◆Previously treated with Interferon? ☐Yes ☐No ◆Pre-Treatment HBV viral load:__________

◆Start date of Hep B therapy:___/___/____ ◆ANC:______________________ ◆Pre-treatment ALT:__________________

◆Liver biopsy ☐Yes ☐No ◆ Most recent ALT:____________ ◆Hgb:______________________________

Prescription Information:

☐Vemlidy® (tenofovir alafenamide) 25mg Take 1 tablet PO once daily Qty: __30__Refill:____	☐Epivir-HBV™ (lamivudine) 100mg Take 1 tablet PO once daily Qty: __30__Refill:____
☐Hepsera™ (adefovir dipivoxil) 10mg Take 1 tablet PO once daily Qty: __30__Refill:____	☐Tyzeka™ (telbivudine) 600mg Take 1 tablet PO once daily Qty: __30__Refill:____
☐Baraculde™(entecavir) ☐0.5mg ☐ 1.0mg Take 1 tablet PO once daily Qty: __30__Refill:___	☐Viread™ (tenofovir disoproxil fumarate) 300mg Take 1 tablet PO once daily Qty: __30__Refill:____
☐Other:______________________________ SIG:__________________Qty:____Refill:___	☐Other:______________________________ SIG:__________________Qty:____Refill:___

Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

☐ I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.

Physician's Signature:____ ☐DAW (Dispense as Written) **Date** _____/_____/________

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

Rep:_____

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1517 17th Street NW, Washington DC 20036

Phone: 202-503-2644 | Fax: 202-503-1721

Our PA Team is here to help! Here is our contact information:
Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check on status of ***pending PA's***, or if you have any questions, call **Dawn** at ext. 221 or **Nick** at ext. 218

- ***Please forward to us any updates you receive from the insurance company regarding approvals or denials***

www.grubbsnw.com

Rep:______