ameripharma SPECIALTY CARE

HEPATITIS B REFERRAL FORM

Phone: 877-778-0318 Fax: 877-778-0399

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female DOB: _____ SS#: _____

Address: _____

Primary Phone#: _____ ☐ cell ☐ home Alt Phone #: _____ ☐ cell ☐ work

Caregiver: _____ Allergies: _____

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 (w/ delta agent) ☐ B18.1 Hepatitis B (w/o 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: _____ Date: _____

Liver Biopsy: ☐ Y / ☐ N Results: _____ Date: _____

Hgb: _____ Date: _____

INSURANCE INFORMATION

Insurance Plan Name: _____ Insurance Phone: _____

Policy Number: _____ Group#: _____ RxBin#: _____ RxPCN#: _____

please fax copy of insurance card (front and back)

PRESCRIPTION	DIRECTIONS	QUANTITY	REFILLS
☐ **Hepsera®** (adefovir dipivoxil)	☐ Take 10 mg once daily by mouth ☐ _____	☐ 30 x 10 mg tablets ☐ _____	
☐ **Baraclude®** (entecavir)	☐ Take 0.5 mg once daily by mouth on an empty stomach ☐ Take 1 mg once daily by mouth on an empty stomach ☐ _____	☐ 30 x 0.5 mg tablets ☐ 30 x 1 mg tablets ☐ _____	
☐ **Tyzeka®** (telbivudine)	☐ Take 600 mg once daily by mouth	☐ 30 x 600 mg ☐ _____	
☐ **Epivir-HBV®** (lamivudine)	☐ Take 100 mg once daily by mouth	☐ 30 x 100 mg tablets	
☐ **Vemlidy®** (tenofovir alafenamide)	☐ Take 25 mg once daily by mouth	☐ 30 x 25 mg tablets	
☐ **Viread®** (tenofovir disoproxil fumarate)	☐ Take 300 mg once daily by mouth	☐ 30 x 300 mg tablets	

PRESCRIBER INFORMATION

Prescriber's Full Name: _____ Office Contact: _____

DEA #: _____ State License #: _____ NPI #: _____

Preferred Method of Contact: ☐ phone ☐ fax ☐ email Preferred contact's email: _____

Office Address: _____

Phone #: _____ Fax #: _____

Prescriber's Signature: _____ Date: _____

By signing above, I authorize Ameripharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

SHIPPING INFORMATION

Ship to: ☐ patient ☐ prescriber's office ☐ alternate

Address: _____