



866 413-3156 toll free phone
 877 834-1231 toll free fax
 QUESTIONS? Please contact us!
 www.REPharmacy.com

Hepatitis B Prescription Referral Form

Send your Rx to: _____

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-up (store location): _____ Injection training by pharmacy? _____

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

2. Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

3. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

4. Diagnosis/Clinical Information Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Diagnosis: _____ ICD-10: _____

5. Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Baraclude®	0.5mg 1mg 0.05mg/ml:	0.5mg tab by mouth daily 1mg tab by mouth daily Other:	30 <input type="checkbox"/> ml	
Epivir HBV	100mg	100mg by mouth daily	30 <input type="checkbox"/>	
Hepsera®	10mg	10mg by mouth daily	30 <input type="checkbox"/>	
HBIG (Hepatitis B Immune Globulin - single use vial)				
Pegasys® Prefilled Syringe ProClick® Vial	180mcg 135mcg	180 mcg SQ once weekly 135 mcg SQ once weekly	28 day supply	
Tyzeka®	600mg	600mg by mouth daily	30	
Vemlidy®	25mg	25mg by mouth daily with food	30	
Viread®	300mg	300mg tab by mouth daily Other:	30	

6. Patient Support Programs Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

 Patient Signature Date

7. Prescriber Signature Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____