MedicoRx Specialty
& HOME INFUSION PHARMACY

# NEW HEPATITIS B REFERRAL FORM

Phone: 818-390-9696 ● Fax: 818-390-9697

## PATIENT INFORMATION

Patient Name: DOB: Sex: M F Weight: lbs. kg.

SSN: Phone: Allergies:

Address: City: State: Zip:

Emergency Contact: Phone:

## INSURANCE INFORMATION

**Please attach front and back of patient's insurance card**

## PRESCRIBER INFORMATION

Prescriber: NPI: DEA: State Lic:

Practice Name:

Address: City: State: Zip:

Phone: Fax: Office Contact: Phone:

## DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

***Primary Diagnosis*:** Hepatitis B HIV – HBV co-infection Other

**MEDICAL ASSESSMENT:** *(Please provide the information below or Fax copies of labs to Fax number provided above.)*

PCR for HBV DNA (Viral Load) copies/ml Date: AST/ALT

Ratio_______/ Date: e-antigen + (HBeAg+) / U e- – (HBeAg-) Co-infected with HIV: Yes N o

- Has patient been treated previously for this condition? Yes No Medication(s):
- Is patient currently on therapy? Yes No Medication(s):
- Will patient stop taking the above medication(s) before starting the new medication? Yes No; if yes, what

## PRESCRIPTION INFORMATION

| MEDICATION | SIG | QTY | REFILL |
|---|---|---|---|
| **Viread 300 mg** | 300 mg po daily | 30 | |
| | Dose adjustment by Creatinine Clearance (if less than 50 ml/min): | | |
| **Baraclude** | 0.5 mg tab po daily (Naïve pt or adolescents ≥ 16 yo) | 30 or 90 | |
| | 1 mg tab po daily (Lamivudine –Refractory pt) | 30 or 90 | |
| | 0.05 mg/ml | 210 ml | |
| | Dose adjustment by Creatinine Clearance (if less than 50 ml/min): | 210 ml | |
| **Hepsera 10 mg** | 10 mg po daily | 30 | |
| | Dose adjustment by Creatinine Clearance (if less than 50 ml/min): | | |
| **Epivir HBV 100 mg** | 100 mg po daily | 30 | |
| **Epivir 150 mg** | 150 mg po BID (only for co-infected pt with HIV) | 60 | |
| **Tyzeka 600 mg** | 600 mg po daily | 30 | |
| | Dose adjustment by Creatinine Clearance (if less than 50 ml/min): | 30 | |
| **HBIG** | (Hepatitis B Immune Globulin- single use vial) *greater than 1560 International Units*/5 ml (*greater than 312 International Units*/ml) | | |
| | 5 ml IM in 2 divided doses, every | 5 ml vial | |
| | 2 ml IM in 2 divided doses, every | 2 of 1 ml vial | |
| | 10,000 International Units(32 ml) in 250 ml NS, IV over _____hour(s), every_______for_______infusions | ____of 5 ml vials | |
| | Infusion @ Physician's office or Home infusion | | |
| | Alt. Dosage: | | |
| **Pegasys** 180 mcg | PFS (pre-filled syringes) Vial "Will dispense PFS (prefilled syringe) unless VIAL is marked" | | |
| | 180 mcg SQ QWK Alternative dosage | 28 days | |
| **Epipen** 0.3 mg IMx1, may repeat Epipen Jr (for Peds less than 30 kg), 0.15 mg IMx1,may repeat | | | |
| **Other:** | | | |

**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. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through MedicoRx Specialty Pharmacy, this prescription shall be forwarded to an eligible pharmacy.**

**IMPORTANT NOTICE:** This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to MedicoRx Specialty Pharmacy or any of its subsidiaries using the contact information provided on this coversheet.