Hepatitis B
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

ACHC ACCREDITED urac ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD-10:

4. Prescription Information: For IV medications attach a copy of your prescription

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Baraclude®**	☐ 0.5mg ☐ 1mg ☐ 0.05mg/ml:	☐ 0.5mg tab by mouth once daily ☐ 1mg tab by mouth once daily ☐ Other:	☐ 30 tablets ☐ _____ mL	
☐ **Epivir HBV**	☐ 100mg	☐ 100mg by mouth once daily	30	
☐ **Hepsera®**	☐ 5mg ☐ 10mg	☐ 5mg by mouth once daily (off-label prophylaxis dose) ☐ 10mg by mouth once daily		
☐ **HBIG** (Hepatitis B Immune Globulin - single use vial)				
☐ **Pegasys®** ☐Prefilled Syringe ☐Vial ☐ProClick®	☐ 180mcg ☐ 135mcg	☐ 180 mcg SQ once weekly ☐ 90 mcg SQ once weekly ☐ 135 mcg SQ once weekly	28 day supply	
☐ **Tyzeka®**	☐ 600mg	☐ 600mg by mouth once daily	30	
☐ **Vemlidy®**	☐ 25mg	☐ 25mg by mouth once daily with food	30	
☐ **Viread®**	☐ 300mg	☐ 300mg by mouth once daily ☐ Other:	30	
☐ **Other:**				
☐ **Other:**				

Ship to: ☐ Patient ☐ Office ☐ Other

4. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.