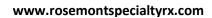
Hepatitis B **Prescription Referral Form** ESCRIBE #: 5700174

Phone: 1.877.592.7988 Fax: 1.800.787.0874







| 1. Patient Information | | | | | | | |
|---|--|--|-------------------------------|-------------------------------------|--------------------------|---------|--|
| Patient Name: | | SSN: | | | DOB: | | |
| Address: | | City: | | State: | Zip: | | |
| Home Phone: | ell Phone: | | Email Addre | ess: | | | |
| Sex: ☐ Male ☐ Female Height: | Weight | : □ lbs. □ kg. | Known A | 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 | | | | | | | |
| 4. Trescription information. For it inedications attach a copy of your prescription | | | | | | | |
| Medication | Dose/Strength | Sig | | | Qty. | Refills | |
| | | □ 0.5mg tab by mouth once daily | | | Qty. | Keilis | |
| □ Baraclude® | ☐ 0.5mg ☐ 1mg | | ☐ 1mg tab by mouth once daily | | | | |
| | □ 0.05mg/ml: | | □ Other: | | | | |
| | _ = 5.558/ | | | | □mL | | |
| □ F=i::i=UDV | □ 100mg | □ 100mg by mouth | ☐ 100mg by mouth once daily | | | | |
| □ Epivir HBV | ☐ 100mg | ☐ 5mg by mouth once daily (off-labe | | al prophylovic doca | 30 | | |
| ☐ Hepsera® | ☐ 5mg ☐ 10mg | ☐ 10mg by mouth once daily (on-label prophylaxis dose) | | | 7 | | |
| | 10mg | 10mg by mouth once daily | | | | | |
| ☐ HBIG (Hepatitis B Immune Globulin - single use via | 1) | | | | | | |
| □ Pegasys® | ☐ 180mcg | ☐ 180 mcg SQ once weekly ☐ 90 mcg SQ once weekly | | 28 day supply | | | |
| ☐ Prefilled Syringe ☐ Vial | ☐ 135mcg | ☐ 135 mcg SQ once weekly | | | | | |
| ☐ ProClick [®] | | | | | | | |
| ☐ Tyzeka® | □ 600mg | ☐ 600mg ☐ 600mg by mouth once daily | | | 30 | | |
| ☐ Vemlidy® | ☐ 25mg ☐ 25mg by mouth once da | | once daily with | food | 30 | | |
| ☐ Viread [®] | ☐ 300mg | ☐ 300mg by mouth once daily | | | 30 | | |
| | | ☐ Other: | | | | | |
| □ Other: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| ☐ Other: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Chin to: Detient Deffice Dether | | | | | | | |
| Ship to: ☐ Patient ☐ Office ☐ Other | | | | | | | |
| 4. Physician Information: | | | | | | | |
| Prescriber Name: | | Prescriber NPI: | | DEA# | | 71:-: | |
| Address: | | City: Fax Number: | | State: | Zip: | | |
| Primary Office Contact: | Fax N | iumber: | | Phone Number: | 1 | | |
| 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 initiative 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 | | | | | | | |
| Confidentiality Statement: This message is intended only for the | ne individual or entity to which it is | addressed. It may contain information w | hich may be proprietary ar | d confidential. It may also contain | privileged, confidential | | |
| Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable leads, including the Health insurance for Ortability and Accountability Adcountability do us are not the intended recipient, please note that you are strictly try prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you. | | | | | | | |
| This prescription is valid only if transmitted by facsimile machine by a licensed prescriber. | | | | | | | |