RE PHARMACY
PASSION FOR LIFE

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:
Select Location

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 ☐ ml	
☐ **Epivir HBV**	☐ 100mg	☐ 100mg by mouth daily	30 ☐	
☐ **Hepsera®**	☐ 10mg	☐ 10mg by mouth daily	30 ☐	
☐ **HBIG** (Hepatitis B Immune Globulin - single use vial)				
☐ **Pegasys®** ☐ Prefilled Syringe ☐ ProClick® ☐ Vial	☐ 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 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** _____

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.