PALMETTO PHARM
USE AS WRITTEN

Phone: 1-800-275-0139 • Fax: 843-972-9395

Date Shipment Needed:_____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

HEPATITIS B REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑ lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑Hepatitis B ❑HIV-HBV Co-infection ❑Other: _____

Medical Assessment: Please provide the information below of fax copies of labs to above number.

PCR for HBV DNA (Viral Load)_____, Date:_____AST/ALT_____CrCl_____

Ratio_____/_____Date:_____❑ e-antigen + (HBeAg+)/❑ e-antigen – (HBeAg-),

- 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: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

❑ **Baraclude**
- ❑ 0.5 mg tab: Take 1 tablet PO daily on empty stomach (Naïve PT) — QTY: 30 Tabs Refills:_____
- ❑ 1 mg tab: Take 1 tablet PO daily on empty stomach (Lamivudine-Refractory or decompensated liverdisease) — QTY: 30 Tabs Refills:_____
- ❑ 0.05 mg/mL oral solution:_____ — QTY:_____ Refills:_____
- ❑ Alternate Dose (CrCL<50 mL/min or Dialysis):_____ — QTY:_____ Refills:_____

❑ **Epivir HBV 100 mg**
- ❑ 100 mg PO daily — QTY: 30 Tabs Refills:_____

❑ **Epivir HBV 150 mg**
- ❑ 150 mg PO BID (only for co-infected PT with HIV) — QTY: 60 Tabs Refills:_____

❑ **Epivir HBV 5mg/ml oral solution**:_____ — QTY:_____ Refills:_____

❑ Alternate Dose (CrCL<50 mL/min or Dialysis):_____ — QTY:_____ Refills:_____

❑ **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 ❑Once or ❑every 28 days. — QTY: 5 mL vial Refills:_____
- ❑ 2 mL IM in 2 divided doses ❑Once or ❑every 28 days. — QTY: 2 of 1 mL vial Refills:_____

❑ **HBIG MD Infusion (1560 International Units/5ml vials)**
- ❑ 20,000 International Units (64mL) in 250 mL NS, IV over_____hour(s), every_____for_____infusions — QTY:_____Vials Refills:_____
- ❑ Alternate Dose:_____ — QTY:_____Vials Refills:_____

❑ **Hepsera 10 mg**
- ❑ 10 mg PO daily — QTY: 30 Tabs Refills:_____
- ❑ Alternate Dose (CrCL<50 mL/min or Dialysis):_____ — QTY:_____ Refills:_____

❑ **Pegasys 180 mcg Prefilled Syringe (OR) ❑Pegasys 180 mcg Vial** **Will dispense prefilled syringe unless vial is marked*
- ❑ 180 mcg SQ once every week — QTY: 28 days Refills:_____
- ❑ Alternate Dose (CrCL<50 mL/min or Dialysis):_____ — QTY:_____ Refills:_____

❑ **Vemlidy 25 mg** — QTY: 30 Tabs Refills:_____
- ❑ 25 mg PO daily with food — QTY: 30 Tabs Refills:_____

❑ **Viread 300 mg**
- ❑ 300 mg PO daily — QTY: 30 Tabs Refills:_____
- ❑ Alternate Dose (CrCL<50 mL/min or Dialysis):_____ — QTY:_____ Refills:_____

❑ **Other:**_____ QTY:_____ Refills:_____

Prescriber's Signature:_____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. 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 Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

3.9.20