Hepatitis B Referral Form

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

AMBER™ SPECIALTY PHARMACY

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Weight/Recorded Date	Date of Birth	Allergies

Emergency Contact	Phone	Primary Caregiver	Phone

Healthcare Provider Information:

Practice/Facility Name	Physician Name	Phone/Fax

Address	City	State	ZIP

Physician NPI #	Nurse/Key Contact	Phone or Pager Number	Email

Diagnosis/Clinical Information:

☐B18.0 Chronic HBV ☐B18.0 Chronic HBV with delta-agent ☐B18.1 Chronic HBV w/o delta-agent Co-infected with HIV? Yes☐ No☐ HBV Viral Load:_____Copies/mL:_____Date:_____

Current SCr: _____ Date: _____ LFTs test: ☐ ALT _____Units/L Other: _____ Date:_____

Cirrhosis: ☐Yes (☐Compensated ☐Decompensated) ☐No Liver Biopsy: ☐No ☐Yes Result: _____

Has patient been treated previously for this condition? ☐No ☐Yes Medication(s): _____

Is patient currently on therapy? ☐No ☐Yes Medication(s): _____

_____

_____

Will patient stop taking the above medication(s) before starting the new medication? ☐No ☐Yes (If yes, what is the washout period?) _____

Other medications patient is currently taking including OTC medications (or fax medication profile): _____

_____

Delivery Information:

☐Patient Home ☐MD Office ☐Other: _____

Medication	Dose/Directions	Quantity	Refills
☐ **Hepsera®** **(adefovir dipivoxil)**	☐ Take 10 mg by mouth once daily ☐ Other: _____	☐ 30-day supply ☐ Other: _____	_____
☐ **Baraclude®** **(entecavir)**	☐ Take 0.5 mg by mouth once daily on an empty stomach ☐ Take 1 mg by mouth once daily on an empty stomach ☐ Other: _____	☐ 30-day supply ☐ Other: _____	_____
☐ **Epivir/ Epivir-HBV®** **(lamivudine)**	☐ Epivir | Take 100 mg by mouth once daily ☐ Epivir-HBV | 150mg po BID *(only for co-infected patient with HIV) #60* ☐ Other: _____	☐ 30-day supply ☐ Other: _____	_____
☐ **Viread®** **(tenofovir disoproxil fumarate)**	☐ Take 300 mg by mouth once daily ☐ Other: _____	☐ 30-day supply ☐ Other: _____	_____
☐ **Vemlidy®** **(tenofovir alafenamide)**	☐ Take 25 mg by mouth once daily with food ☐ Other: _____	☐ 30-day supply ☐ Other: _____	_____
☐ _____	☐ _____	☐ 30-day supply ☐ Other: _____	_____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)