

Hepatitis B Referral Form

Phone (888) 370.1724 Fax (877) 645.7514
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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
<input type="checkbox"/> Hepsera® (adefovir dipivoxil)	<input type="checkbox"/> Take 10 mg by mouth once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Baraclude® (entecavir)	<input type="checkbox"/> Take 0.5 mg by mouth once daily on an empty stomach <input type="checkbox"/> Take 1 mg by mouth once daily on an empty stomach <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Epivir/Epivir-HBV® (lamivudine)	<input type="checkbox"/> Epivir Take 100 mg by mouth once daily <input type="checkbox"/> Epivir-HBV 150mg po BID (only for co-infected patient with HIV) #60 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Viread® (tenofovir disoproxil fumarate)	<input type="checkbox"/> Take 300 mg by mouth once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Vemlidy® (tenofovir alafenamide)	<input type="checkbox"/> Take 25 mg by mouth once daily with food <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 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) _____

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