HEPATITIS B REFERRAL FORM

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

**** Please include a copy of the front and back of insurance card ****

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart				Therapy Start Date	
Cirrhosis ☐ Yes ☐ No ☐ Compensated ☐ Decompensated	CrCl	Scr:	AST/ALT:	Co-infection ☐ HCV ☐ HIV	
HBV DNA Viral Load (copies/ml):	Date of Labwork:	HBeAG antigen ☐ positive ☐ negative			
Liver Biopsy ☐ Yes ☐ No Date of liver biopsy:	Results of liver biopsy:	ANC:	Draw Date:	Hgb:	Draw Date:
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)					
Drug Allergies ☐ NKDA ☐ Yes (please list)					
Other Allergies (please list)					
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)					
ICD-10 Code ☐ B18.0 Chronic HBV with Delta-agent ☐ B18.1 Chronic HBV w/o Delta-agent ☐ B19.10 Unspecified HBV w/o Hepatic Coma ☐ B19.11 Unspecified HBV w/ Hepatic Coma ☐ Other:					

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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 substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Hepsera® (adefovir)	☐ 10 mg tablet	☐ Take 1 tablet by mouth once daily ☐ _____		
☐ Baraclude® (entecavir)	☐ 0.5 mg tablet ☐ 1 mg tablet ☐ 0.05 mg/mL oral solution	☐ Take 1 tablet by mouth daily on an empty stomach ☐ _____		
☐ Epivir	☐ 150 mg	☐ 150 mg by mouth twice daily (only for PT co-infected with HIV)	60	
	☐ 300 mg	☐ 300 mg by mouth once daily (only for PT co-infected with HIV)	30	
☐ Epivir-HBV® (lamivudine)	☐ 100 mg tablet ☐ 5 mg/ml oral solution	☐ Take 1 tablet by mouth once daily ☐ _____		
☐ Viread® (tenofovir disoproxil fumarate)	☐ 300 mg tablet ☐ Other: _____	☐ Take 300 mg by mouth daily ☐ _____	30	
☐ Vemlidy® (tenofovir alafenamide)	☐ 25 mg tablet	☐ Take 1 tablet by mouth daily with food ☐ _____		
☐ Other:				

_____ Prescriber Signature

_____ Date

_____ Supervising Physician Signature (where required by state law)

_____ Date

_____ DAW (Dispense as Written)

_____ Date

_____ Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0222