Elwyn SPECIALTY CARE Rx
Part of The Elwyn Pharmacy Group
*Dedicated to Improving Our Patients' Health*

June 2017

# HEPATITIS B REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

| PRACTICE NAME | PRACTICE ADDRESS | CONTACT INFORMATION | LICENSE INFORMATION |
|---|---|---|---|
| | | | |

**REFERRAL SOURCE INFORMATION**

| | | |
|---|---|---|
| ☐_____ #_____ | ☐_____ #_____ | ☐_____ #_____ |
| ☐_____ #_____ | ☐_____ #_____ | ☐_____ #_____ |
| ☐_____ #_____ | ☐_____ #_____ | ☐_____ #_____ |
| ☐_____ #_____ | ☐_____ #_____ | ☐_____ #_____ |
| ☐_____ #_____ | ☐_____ #_____ | ☐_____ #_____ |

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis Code ☐ _____ Diagnosis_____ Weight_____
Testing? ☐ Yes ☐ No Results_____
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work_____

## PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

### BARACLUDE
☐ 0.5mg tablet ☐ 1 mg tablet ☐ 0.05mg/ml
SIG: ☐ 0.5mg tablet by mouth daily
QTY: 30 Refills:_____

SIG: ☐ 1mg tablet by mouth daily
QTY: 30 Refills:_____

SIG: ☐ Other:_____
QTY: ____ml Refills:_____

### EPIVIR HBV ☐ 100mg tablet ☐ 5mg/mL
SIG: ☐ 100mg tablet by mouth daily
QTY: 30 Refills:_____

SIG: ☐ Other:_____
QTY: ____ml Refills:_____

### HEPSERA ☐ 10mg tablet
SIG: ☐ 10mg tablet by mouth daily
QTY: 30 Refills:_____

### HGIB (Hepatitis B Immune Globulin - single use vial)
SIG: ☐_____
QTY: _____ Refills:_____

### PEGASYS
☐ **ProClick** 180mcg Autoinjector (NDC 004-0365-30)
Inject SQ weekly
☐ **Pre-Filled Syringe** 180mcg/0.5ml (NDC 004-0357-30)
Inject SQ weekly
☐ Other _____
QTY: ☐ 1 month ☐ 3 month Refills:_____

### TYZEKA ☐ 600mg tablet
SIG: ☐ 600mg tablet by mouth daily
QTY: 30 Refills:_____

### VEMLIDY ☐ 25mg tablet
SIG: ☐ Take one tablet by mouth daily
QTY: 30 Refills:_____

### VIREAD ☐ 300mg tablet
SIG: ☐ 300mg tablet by mouth daily
QTY: 30 Refills:_____

SIG: ☐ Other:_____
QTY: _____ Refills:_____

### OTHER _____
Sig _____
Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS)_____ **Date**_____



Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.