Across
Specialty Pharmacy

HEPATITIS B REFERRAL FORM

PH (770) 7460130 | FAX (770) 7460131
NCPDP 1175288 | NPI 1275142614

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 #

CLINICAL INFORMATION

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

Medication	Dose / Strength	Dose Direction	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:				

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _______________ Date _______

Supervising Physician Signature (where required by state law) _______________ Date _______

DAW (Dispense as Written) _______________ Date _______

Brand Necessary (must handwrite) _______________

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