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MedRX Infusion
www.medrxinfusion.com

Hepatitis B Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____

Diagnosis (ICD 10 Code):_____

Fibrosis score:_____(kPa) HBeAg: ☐+ ☐- (+ since:_____) Viral Load/Date:_____ / _____ Patient treated on therapy: ☐ Y ☐ N

Moderate to Severe Necroinflammation: ☐ Y ☐ N Prior Therapies:_____

4. Prescription Information ☐ DAW1- Dispense as written. Do not substitute for generic

Medication	Dose	Directions	Dispense	Refill
☐ **Baraclude** (Entecavir)	☐ 0.5mg ☐ 1mg	Take 1 tablet PO daily on empty stomach (Naïve PT) Other: _____	30 tabs	
☐ **Epivir** (Lamuvidine)	☐ 100mg ☐ 150mg	Take 1 tablet PO daily Other: _____	☐ 30 tabs ☐ 60 tabs	
☐ **Hepsera** (adefovir)	10mg	Take 1 tablet PO daily Other: _____	30 tabs	
☐ **Viread** (tenofovir disoproxil fumarate)	300mg	Take 1 tablet PO daily Other: _____	30 tabs	
☐ **Vemlidy** (tenofovir alafenamide)	25mg	Take 1 tablet PO daily Other: _____	30 tabs	
☐ **Pegasys** (Peginterferon Alfa-2a)	☐ 180MCG/ML 1ML soln vials ☐ PF syringe 180MCG/0.5ML	Inject 180 mcg SQ once weekly for 48 weeks Other: _____	☐ 1 month supply ☐ Other_____ Disp. QS supplies	
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS._____ Date _____