HEPATITIS B REFERRAL FORM

BIOMATRIX SpRx **TEL:** 855-359-9679 **FAX:** 610-545-6030

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	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

	#		#		#
☐ ______	# ______	☐ ______	# ______	☐ ______	# ______
☐ ______	# ______	☐ ______	# ______	☐ ______	# ______
☐ ______	# ______	☐ ______	# ______	☐ ______	# ______

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 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
☐ 0.5 mg tablet ☐ 1 mg tablet ☐ 0.05 mg/ml
SIG: ☐ 0.5 mg tablet by mouth daily
QTY: 30 Refills: ______
SIG: ☐ 1 mg tablet by mouth daily
QTY: 30 Refills: ______
SIG: ☐ Other:______
QTY: ____ml Refills: ______

EPIVIR HBV
☐ 100 mg tablet ☐ 5 mg/mL
SIG: ☐ 100 mg tablet by mouth daily
QTY: 30 Refills: ______
SIG: ☐ Other:______
QTY: ____ml Refills: ______

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

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

☐ OTHER ______
SIG: ______
QTY:______ Refills: ______

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

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

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

VIREAD
☐ 300 mg tablet
SIG: ☐ 300 mg 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 BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature ______ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**______
Prescriber's Email______

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