HEPATITIS B REFERRAL FORM

GLEN ROCK Medical Pharmacy
Part of The Elwyn Pharmacy Group

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

July 2017

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 Glen Rock Medical Pharmacy 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 **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.