GLEN ROCK MEDICAL PHARMACY
A BIOMATRIX Company

FEB 2018

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 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**______

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Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.

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