ivira specialty pharmacy

Hepatitis B Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____ PREFERRED CONTACT #: _____

DATE OF REFERRAL: _____ SECONDARY CONTACT #: _____

SOCIAL SECURITY NUMBER: _____ ADDRESS: _____

DATE OF BIRTH: _____ GENDER: ☐ F ☐ M CITY, STATE, ZIP: _____

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ B18.0 - Hepatitis B (with delta agent) ☐ B18.1 - Hepatitis B (without delta agent) ☐ Other: _____-_____

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any): _____ APPROX START DATE: _____ APPROX. END DATE: _____ REASON FOR DISCONTINUATION: _____

CLINICAL INFORMATION:

ALLERGIES: ☐ NKDA
TREATMENT NAIVE: ☐ Y ☐ N
FIRST DOSE: ☐ Y ☐ N

Pre-treatment HBV Viral Load: _____
ANC: _____/mm³ Date: _____
Hgb: _____g/dL Date: _____

Pre-treatment ALT: _____ Date: _____
Most recent ALT: _____ Date: _____
Liver Biopsy: _____

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P

MEDICATION SELECTION:

Baraclude (entecavir) 0.5 mg/1 mg tablets	☐ TAKE 0.5 MG BY MOUTH ONCE DAILY ON AN EMPTY STOMACH ☐ TAKE 1 MG BY MOUTH ONCE DAILY ON AN EMPTY STOMACH ☐ _____	☐ 30 ☐ _____	REFILLS:____
Hepsera adefovir dipivoxil	☐ TAKE 10 MG BY MOUTH ONCE DAILY ☐ _____	☐ 30 ☐ _____	REFILLS:____
Vemlidy tenofovir alafenamide 25mg tablets	☐ TAKE 25 MG BY MOUTH ONCE DAILY WITH FOOD	☐ 30	REFILLS:____
Viread 300mg tablets tenofovir disoproxil fumarate	☐ TAKE 300 MG BY MOUTH ONCE DAILY	☐ 30	REFILLS:____
EPIVIR-HBV (lamivudine)	☐ TAKE 100 MG BY MOUTH ONCE DAILY	☐ 30	REFILLS:____

PRESCRIBER INFORMATION:

PHYSICIAN NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ LICENSE #: _____

CITY, STATE, ZIP: _____ NPI: _____

PHYSICIAN SIGNATURE: _____ DATE: _____