HAWAII SPECIALTY™ PHARMACY

HEPATITIS B REFERRAL FORM

MDX Hawai'i

Please complete and attach to MDX prior

Authorization form

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alternate Phone:	Phone: Fax:
Email:	Office Email:
Soc. Sec #: (Last 4 Digits)	Key Office Contact
Date of Birth: Sex: ☐ Male ☐ Female	State LIC # NPI # DEA#
Weight: ☐ lbs ☐ Kg Height: ☐ ft ☐ cm BMI:	

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:		**Viral Load/Date:**	**Fibrosis Score:**
HBeAg: + / -	**HBsAg: + / - (+ since:)**	**ALT:**	**SrCr:**
Moderate to severe active necroinflammation: ☐ Y / ☐ N		**Prior Therapies:**	
☐ **Patient is currently on therapy (Start date:)**			

MEDICATIONS AND DIRECTIONS

Medication	Strength	Directions	Quantity	Refill
☐ **Baraclude®**	☐ 0.5 mg ☐ 1 mg	☐ Take 1 tablet by mouth once daily	☐ **30 days supply**	
☐ **Epivir®**	☐ 100 mg	☐ Directions:		
☐ **Hepsera®**	☐ 10 mg			
☐ **Pegasys®**	☐ 180 mcg/ vial	☐ Inject SQ once weekly	☐ **30 days supply**	
	☐ 180 mcg/ 0.5 ml			
	☐ PFV			
	☐ autojector			
	☐ 135 mcg/ 0.5 ml autojector			
☐ **Vemlidy®**		☐ Directions:	☐ **30 days supply**	
☐ **Viread®**	☐ 300 mg			
☐ **Other**				

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
x		