



HAWAII SPECIALTY™
PHARMACY

HEPATITIS B REFERRAL FORM

MDX Hawaii

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 #: _____	Key Office Contact: _____
Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	State LIC # _____ NPI # _____ DEA# _____
Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> Kg Height: _____ <input type="checkbox"/> ft <input type="checkbox"/> cm BMI: _____	

INSURANCE INFORMATION: <input type="checkbox"/> DEMOGRAPHIC SHEET <input type="checkbox"/> UNIVERSAL CLAIM FORM <input type="checkbox"/> INSURANCE CARDS (front + back)												
<i>*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)</i>												
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Diagnosis / ICD-10: _____</td> <td style="width: 25%;">Viral Load/Date: _____</td> <td style="width: 25%;">Fibrosis Score: _____</td> </tr> <tr> <td>HBsAg: + / - HBsAg: + / - (+ since: _____)</td> <td>ALT: _____</td> <td>SrCr: _____</td> </tr> <tr> <td>Moderate to severe active necroinflammation: <input type="checkbox"/> Y / <input type="checkbox"/> N</td> <td colspan="2">Prior Therapies: _____</td> </tr> <tr> <td><input type="checkbox"/> Patient is currently on therapy (Start date: _____)</td> <td colspan="2"></td> </tr> </table>	Diagnosis / ICD-10: _____	Viral Load/Date: _____	Fibrosis Score: _____	HBsAg: + / - HBsAg: + / - (+ since: _____)	ALT: _____	SrCr: _____	Moderate to severe active necroinflammation: <input type="checkbox"/> Y / <input type="checkbox"/> N	Prior Therapies: _____		<input type="checkbox"/> Patient is currently on therapy (Start date: _____)		
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HBsAg: + / - HBsAg: + / - (+ since: _____)	ALT: _____	SrCr: _____										
Moderate to severe active necroinflammation: <input type="checkbox"/> Y / <input type="checkbox"/> N	Prior Therapies: _____											
<input type="checkbox"/> Patient is currently on therapy (Start date: _____)												

MEDICATIONS AND DIRECTIONS				
Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Baraclude®	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 days supply	
<input type="checkbox"/> Epivir®	<input type="checkbox"/> 100 mg	<input type="checkbox"/> Directions:		
<input type="checkbox"/> Hepsersa®	<input type="checkbox"/> 10 mg			
<input type="checkbox"/> Pegasys®	<input type="checkbox"/> 180 mcg/ vial	<input type="checkbox"/> Inject SQ once weekly	<input type="checkbox"/> 30 days supply	
	<input type="checkbox"/> 180 mcg/ 0.5 ml			
	<input type="checkbox"/> PFV			
	<input type="checkbox"/> autojector			
<input type="checkbox"/> 135 mcg/ 0.5 ml autojector				
<input type="checkbox"/> Vemlidy®		<input type="checkbox"/> Directions:	<input type="checkbox"/> 30 days supply	
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300 mg			
<input type="checkbox"/> 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 _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<small>Legal Notice: This fax transmission may contain confidential information belonging to the sender which is legally privileged. This information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the consents of this faxed information is strictly prohibited. Please notify us by phone to arrange for the return of the original documents. This prescription may be filled at a pharmacy of the patient's choice</small>		