Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Hepatitis B Prescription Referral Form

Send your RX to: | Access Specialty Pharmacy Fax: 661-489-3553 | If you have any questions or concerns, Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ Deliver to: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up Injection training by pharmacy? _____

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. Kg.
Soc. Sec #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please Fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Provider Name: _____ DEA #: _____ NPI#: _____
Address: _____ Phone: _____ Fax: _____
City, State, ZIP: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

Diagnosis: _____ **ICD-10:** _____

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Baraclude**	☐ 0.5mg tabs ☐ 1mg tabs ☐ 0.05mg/ml oral soln	0.5mg tablet by mouth once daily 1mg tablet by mouth daily Other: _____	30 _____ml	
☐ **Epivir HBV**	☐ 100mg ☐ 5mg/ml oral soln	100mg by mouth once daily Other: _____	30 _____ml	
☐ **Hepsera**	☐ 10mg	10mg by mouth once daily	30	
☐ **HBIG** *(Hepatitis B Immune Globulin-single use vial)*	☐ HepaGam B ☐ HyperHep B S/D ☐ Nabi-HB			
☐ **Pegasys** • Prefilled syringe • Vial • Proclick	☐ 180mcg	☐ 180mcg SQ once weekly ☐ 90mcg SQ once weekly	28 day supply	
☐ **Vemlidy**	☐ 25mg	☐ 25mg by mouth once daily with food	30	
☐ **Viread**	☐ 300mg	☐ 300mg by mouth once daily ☐ Other: _____	30	
☐ **Intron A**	☐ 6,000,000 units/ml (3.8 ml) ☐ 10,000,000 units/ml (3.2 ml) ☐ 10,000,000 units (1 each) PF ☐ 18,000,000 units (1 each) PF ☐ 50,000,000 units (1 each) PF	☐ 5 million units IM or SQ once daily ☐ 10 million units IM or SQ 3 times per week		
☐ **Other**				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ **Date:** _____

Prescriber Signature: Prescriber, please sign and date below

_____ _____ _____ _____
Dispense as written **Date** **Substitution Permissible** **Date**

# of Prescriptions:

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