CALIFORNIA SPECIALTY PHARMACY

HEPATITIS B REFERRAL FORM

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

PATIENT INFORMATION:	**PHYSICIAN INFORMATION:** Ship to: ☐Physician's Office ☐Patient's Home
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: ☐ Male ☐ Female	State LIC # NPI # DEA#
Weight: ☐ lbs ☐Kg Height: ☐ ft ☐ cm BSA:	

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:)**			

Per state-specific law, prescriptions will be dispensed as generic, If applicable, unless noted otherwise: _____

MEDICATIONS AND DIRECTIONS

Prescription	Directions	Quantity	Refill
☐ **Hepsera®** (adefovir diplvoxil)	☐ Take 10 mg by mouth once daily ☐ _____	☐ 30 X 10 mg tablets ☐ _____	_____
☐ **Baraclude®** (entecavir)	☐ Take 0.5 mg by mouth once daily on an empty stomach	☐ 30 X 0.5 mg tablets	_____
	☐ Take 1 mg by mouth once daily on an empty stomach	☐ 30 X 1 mg tablets	
	☐ _____	☐ _____	
☐ **Epivir-HBV®** (lamivudine)	☐ Take 100 mg by mouth once daily	☐ 30 X 100 mg tablets	_____
☐ **Viread®** (tenofovir disoproxil fumarate)	☐ Take 300 mg by mouth once daily	☐ 30 X 300 mg tablets	_____
☐ **Vemlidy®** (tenofovir alafenamide)	☐ Take 25 mg by mouth once daily with food	☐ 30 X 25 mg tablets	_____
☐ **Other**		☐ 30 day supply	_____

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

I authorize California 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		

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