US Bioservices
AmerisourceBergen

Hepatitis B Referral Form

Phone: (866) 223-7914
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Last Name: _____ Home Phone:_____ Work/Mobile Phone:_____

First Name: _____ Home Address:_____

S.S. #:_____ Date of Birth:_____ City:_____ State:_____ Zip:_____

Guardian/Caregiver:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____ Secondary ICD-10:_____ **HBsAG Result*:** Value:_____ Date:_____

Concurrent Medications:_____ **Serum HBV RNA*:** Value:_____ Date:_____

Allergies:_____ ALT:_____ Date:_____ AST:_____ Date:_____

Meds Tried & Failed:_____ *Please include a copy of the patient's most recent lab results.

5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
BARACLUDE®	☐ 0.5mg tabs ☐ 1mg tabs	☐ 0.5mg PO QD ☐ 1mg PO QD		
EPIVIR-HBV	☐ 100mg tabs ☐ 5mg/mL Oral Solution	• _____ mg PO QD		
HEPSERA®	☐ 10mg tabs	• 10mg PO QD		
INTRON A®		• Inject _____ million IU SC 3 times per week for 16 weeks		
PEGASYS®	☐ 180mcg/mL SDV ☐ 180mcg/0.5mL PFS ☐ 180mcg/0.5mL Autoinjector	☐ Inject 180mcg SC QW x 40 weeks ☐ Other:_____		
VEMLIDY®	☐ 25mg tabs	• 25mg PO QD with food		
VIREAD®	☐ 150mg tabs ☐ 200mg tabs ☐ 250mg tabs ☐ 300mg tabs ☐ 40mg/1g Oral Powder	☐ 300mg PO QD ☐ Other:_____		
Hepatitis B Immune Globulin	☐ **NABI-HB®** ☐ **HyperHEP B® S/D** ☐ **HEPAGAM B®**			
☐				
☐				

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

Patient Signature _____ Date _____ / _____ / _____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____