



# RICHMOND PHARMACY

## Specialty Script

PHONE: 718-818-2178 • FAX: 718-818-2179

355 Bard Ave • Staten Island, NY 10310 • [www.RichmondSpecialty.com](http://www.RichmondSpecialty.com)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

### HEPATITIS B REFERRAL FORM

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

**PATIENT INFORMATION:** Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

**PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION**

#### CLINICAL INFORMATION

##### DIAGNOSIS

B 18.1 Hepatitis B

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

B 18.2 Hepatitis C

B 20 HIV / Aids

Other \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

#### PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<input type="checkbox"/> Baraclude®	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 0.05mg/ml:	<input type="checkbox"/> 0.5mg tab by mouth daily <input type="checkbox"/> 1mg tab by mouth daily <input type="checkbox"/> Other: _____	30 [ ] ml	
<input type="checkbox"/> Epivir HBV	<input type="checkbox"/> 100mg	<input type="checkbox"/> 100mg by mouth daily	30 [ ]	
<input type="checkbox"/> Hepsera®	<input type="checkbox"/> 10mg	<input type="checkbox"/> 10mg by mouth daily	30 [ ]	
<input type="checkbox"/> HBIG (Hepatitis B Immune Globulin - single use vial)				
<input type="checkbox"/> Pegasys® <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> ProClick®	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 180 mcg SQ once weekly <input type="checkbox"/> 90 mcg SQ once weekly <input type="checkbox"/> 135 mcg SQ once weekly	28 day supply	
<input type="checkbox"/> Tyzeka®	<input type="checkbox"/> 600mg	<input type="checkbox"/> 600mg by mouth daily	30	
<input type="checkbox"/> Vemlidy®	<input type="checkbox"/> 25mg	<input type="checkbox"/> 25mg by mouth daily with food	30	
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg by mouth daily <input type="checkbox"/> Other: _____	30	
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

For additional information please visit our website [www.RichmondSpecialty.com](http://www.RichmondSpecialty.com)  
ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • (718) 818-2178