Hepatitis B Prescription Referral Form

www.pyramidspharmacy.com

All our referral forms available on our website.

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Houston, Texas, 77079
Toll Free Phone: (877) 866-9579
Toll Free Fax: (877) 866-9578

500 Kobayashi Rd ste E
Webster, TX ,77598
Toll Free Phone: (855) 339-1931
Toll Free Fax: (855) 339-1930

Date Medication Needed: ______________ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): ______________ 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

______________ ______________ **DEA#:** ________ **NPI#:** ________ **Tax ID#:** ________

Address: ______________ **Phone:** (____) ______ - ______ **Fax:** (____) ______ - ______

City: ______________ **State:** ______ **Zip:** ______ **Key Contact:** ______________ **Phone:** (____) ______ - ______

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: ______________ **ICD-9:** ______________

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Baraclude®	0.5mg 1mg 0.05mg/ml:	0.5mg tab by mouth daily 1mg tab by mouth daily **Other:**	30 ml	
Epivir HBV	100mg	100mg by mouth daily	30	
Hepsera®	10mg	10mg by mouth daily	30	
HBIG (Hepatitis B Immune Globulin - single use vial)				
Pegasys® Prefilled Syringe Vial ProClick®	180mcg 135mcg	180 mcg SQ once weekly 90 mcg SQ once weekly 135 mcg SQ once weekly	28 day supply	
Tyzeka®	600mg	600mg by mouth daily	30	
Viread®	300mg	300mg by mouth daily **Other:**	30	

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

Substitution Permissable ______________ Date ______________ Dispense as written ______________ Date ______________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

# of Prescriptions: ______________