

Hepatitis B  
 Prescription Referral Form  
 Bushnell: Phone: 1.352.793.8000  
 Fax: 1.352.793.8007  
 Wildwood: Phone: 1.352.748.9900  
 Fax: 1.352.748.9902



**SAFE SCRIPT**  
 PHARMACY  
 Bushnell | Wildwood



www.safescriptpharmacy.com

**1. Patient Information**

Patient Name:		SSN:	DOB:
Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Known Allergies:

**2. Insurance Information:**

Please fax front and back copy of all Insurance cards (Prescription and Medical)

**3. Diagnosis/Clinical Information:**

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD-10:
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**4. Prescription Information: For IV medications attach a copy of your prescription**

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 once daily <input type="checkbox"/> 1mg tab by mouth once daily <input type="checkbox"/> Other:	<input type="checkbox"/> 30 tablets <input type="checkbox"/> ____ mL	
<input type="checkbox"/> Epivir HBV	<input type="checkbox"/> 100mg	<input type="checkbox"/> 100mg by mouth once daily	30	
<input type="checkbox"/> Hepsera®	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	<input type="checkbox"/> 5mg by mouth once daily (off-label prophylaxis dose) <input type="checkbox"/> 10mg by mouth once daily		
<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 once daily	30	
<input type="checkbox"/> Vemlidy®	<input type="checkbox"/> 25mg	<input type="checkbox"/> 25mg by mouth once daily with food	30	
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg by mouth once daily <input type="checkbox"/> Other:	30	
<input type="checkbox"/> Other:				
<input type="checkbox"/> Other:				

Ship to:  Patient  Office  Other

**4. Physician Information:**

Prescriber Name:	Prescriber NPI:	DEA#:
Address:	City:	State: Zip:
Primary Office Contact:	Fax Number:	Phone Number:
Office Contact Email:		

**Prescriber Signature:** Prescriber, please sign and date below

\*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

Dispense as written  Substitution Permissible

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender. Immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

**This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.**