HEPATITIS B PRESCRIPTION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: ________ ❑Male ❑Female SS#: ________ DOB: ________

Address: ________ City, State, Zip: ________

Primary Phone: ________ ❑Home ❑Cell ❑Work Alternate Phone: ________ ❑Home ❑Cell ❑Work

Email: ________ Height: ________ Weight: ________

Allergies: ________ Comorbidities: ________

PRESCRIBER INFORMATION

Prescriber Name: ________ Office Contact: ________

Address: ________ City, State, Zip: ________

Phone: ________ Fax: ________

NPI: ________ DEA: ________

SHIPPING INFORMATION

Ship To: ❑Patient ❑Physician/Clinic ❑Realo Location: ________

Date Shipment Needed By: ________ ❑Alternate Location: ________

Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis ICD-9: ❑070.20 Hepatitis B ❑070.30 Hepatitis B ❑Other: ________

Previously treated with interferon? ❑yes ❑no Start date of hep B therapy: ________

Pre-treatment ALT: ________ Date: ________ Most recent ALT: ________ Date: ________

Pre-treatment HBV viral load: ________ Date: ________ ANC: ________ /mm³ Date: ________

Liver biopsy (❑yes ❑no) results: ________ Date: ________ Hgb: ________ g/dL Date: ________

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	QUANTITY	REFILLS	MEDICATION	STRENGTH	QUANTITY	REFILLS
❑Hepsera® Directions: Take 1 tablet by mouth once daily	10 mg	30		❑Tyzeka® Directions: Take 1 tablet by mouth once daily	600 mg	30	
❑Baraclude® Directions: Take 1 tablet by mouth once daily	.5 mg	30		❑Epivir-HBV® Directions: Take 1 tablet by mouth once daily	100 mg	30	
❑Baraclude® Directions: Take 1 tablet by mouth once daily	1 mg	30		❑Viread® Directions: Take 1 tablet by mouth once daily	300 mg	30	
❑Vemlidy® Directions: Take 1 tablet by mouth once daily	25 mg	30					

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissable - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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