Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

Padek Healthcare Hepatitis B Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Diagnosis _____ Biospsy ☐ Yes ☐ No Results _____ Previously treated ☐ Yes ☐ No If yes, what drugs _____

HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

HEPATITIS B ORAL THERAPIES

☐ **Baraclude 0.5mg** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Baraclude 1.0mg** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Epivir HBV 100mg** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Hepsara 10mg** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Tyzeka 600mg** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Truvada** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Vemlidy 25mg**
Sig: 1 Tablet po QD with food QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

Testing: Prior to initiation of VEMLIDY, test patients for HIV infection. VEMLIDY alone should not be used in patients with HIV infection. Assess serum creatinine, serum phosphorous, estimated creatinine clearance, urine glucose, and urine protein before initiating VEMLIDY and during therapy in all patients as clinically appropriate.

☐ **Viread** Sig: 1 Tablet po QD QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months Additional Directions:_____

☐ **Other:** _____ Sig: _____ QTY: ☐ 1 Month ☐ 3 Months Refill:_____Months

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127