Procare PHARMACY

1084 Lee Rd, Suite 4, Orlando, FL 32810
www.myprocarepharmacy.com
Tel:(407)730-2770 / Fax:(407)730-2764 / Toll free: (844)571-6805

Hepatitis B Prescription Referral Form (Form 3B)

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

Provider Name: **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-10:** _____

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	
Vemlidy®	25mg	25mg by mouth daily with food	30	
Viread®	300mg	300mg by mouth daily **Other:**	30	

PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____