COTTRILL'S SP
1-844-268-8745

HEPATITIS B
PATIENT REFERRAL & Rx FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS
PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name ______________________ First Name ______________________ DOB ______________

Address ______________________ City ______________ State ____________ Zip ____________

Gender: ☐ Male ☐ Female Height ________ Weight ________ Social Security # ______________

Home Phone ____________ Cell ____________ Email Address ______________________

Allergies ______________________ Emergency Contact Name ______________________ Phone ____________

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance ______________ Policy # ______________ Group # __________ Phone ____________

Policy Holder's Name ______________________________________ DOB ______________

Secondary Insurance ______________ Policy # ______________ Group # __________ Phone ____________

Policy Holder's Name ______________________________________ DOB ______________

CLINICAL INFORMATION

Primary Diagnosis: ______________________ Diagnosis Code: ________ Pre-treatment ALT and Date: ______________

Secondary Diagnosis: ______________________ Diagnosis Code: ________ Most recent ALT and Date: ______________

Viral Load: ______________ Date: ______________

Liver Biopsy: ______________ Date: ______________

HIV Positive
☐ No
☐ Yes

HBV Treatment History
☐ Naive
☐ Retreatment
☐ Partial Relapse

List previous treatment regimens:
____
____

MEDICATIONS

Medication	Dose/Strength	Quantity	Directions	Refill
☐ **Baraclude**® **(Entecavir)**	☐ 0.5 mg tablet ☐ 1 mg tablet	30	Take one tablet by mouth once daily	______
☐ **Epivir- HBV**® **(Lamivudine)**	100 mg tablet	30	Take one tablet by mouth once daily	______
☐ **Hepsera**® **(Adefovir Dipivoxil)**	10 mg tablet	30	Take one tablet by mouth once daily	______
☐ **Pegasys**® **Proclick (Peginterferon alfa-2a)**	☐ 135 mcg autoinjector ☐ 180 mcg autoinjector	4	☐ Inject 135 mcg under the skin once a week ☐ Inject 180 mcg under the skin once a week	______
☐ **Tyzeka**® **(Telbivudine)**	600 mg tablet	30	Take 1 tablet by mouth once daily	______
☐ **Viread**® **(Tenofovir Disoproxil Fumarate)**	300 mg tablet	30	Take one tablet by mouth once daily	______
☐ **Other:** ______________	______________	________	______________________	______

EDUCATION AND DELIVERY INSTRUCTIONS

Education: ☐ Cottrill's Specialty Pharmacy to coordinate injection ☐ training Physician's office to provide injection training

Deliver to: ☐ Patient's home ☐ Physician's Office ☐ 1st dose to physician's office - remaining to patient home

PHYSICIAN INFORMATION

Physician Name ______________________________ NPI# ______________________

License # ______________________ State ______________ DEA# ______________________

Address ______________________ City______________ State ____________ Zip______________

Phone______________________ Fax______________________ Office Contact ______________

______________________ ______________________ ______________

Product Selection Permitted **Dispense as Written** **Date**

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments