



TODT HILL PHARMACY

SPECIALTY PHARMACY

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HEPATITIS B PRESCRIPTION REFERRAL FORM

DATE NEEDED BY SHIP to PATIENT OFFICE OTHER

PATIENT INFORMATION

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ ALTERNATE PHONE _____

SS# _____ DOB _____

MALE FEMALE HEIGHT _____ WEIGHT _____ AGE _____

PRESCRIBER INFORMATION

PRESCRIBER NAME _____

DEA # _____ NPI _____ STATE LICENSE# _____

GROUP/HOSPITAL _____

ADDRESS _____

CITY, STATE, ZIP _____

MAIN PHONE _____ FAX _____

CONTACT PERSON _____ PHONE _____

PLEASE FAX COPY OF PRESCRIPTION CARD FRONT AND BACK CLINICAL NOTES MEDICAL CARD FRONT AND BACK

DIAGNOSIS / CLINICAL INFORMATION

DIAGNOSIS _____ ICD - 10 _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> BARACLUDE	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 Mmg <input type="checkbox"/> 0.05 mg/ml	<input type="checkbox"/> 0.5 mg TAB BY MOUTH DAILY <input type="checkbox"/> 1 mg TAB BY MOUTH DAILY <input type="checkbox"/> OTHER	30 [] ml	
<input type="checkbox"/> EPIVIR HBV	<input type="checkbox"/> 100 mg	<input type="checkbox"/> 100 mg BY MOUTH DAILY	30 []	
<input type="checkbox"/> HEPSERA	<input type="checkbox"/> 10 mg	<input type="checkbox"/> 10 mg BY MOUTH DAILY	30 []	
<input type="checkbox"/> VEMLIDY	<input type="checkbox"/> 25 mg	<input type="checkbox"/> 25 mg BY MOUTH DAILY WITH FOOD	30	
<input type="checkbox"/> VIREAD	<input type="checkbox"/> 300 mg	<input type="checkbox"/> 300 mg BY MOUTH DAILY <input type="checkbox"/> OTHER	30	
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

PATIENT SUPPORT PROGRAMS: PLEASE SIGN AND DATE BELOW TO ENROLL IN THE PHARMACEUTICAL COMPANY ASSISTED PATIENT SUPPORT PROGRAM

PATIENT SIGNATURE _____

DATE _____

PRESCRIBER SIGNATURE: PRESCRIBER, PLEASE SIGN AND DATE BELOW

SUBSTITUTION PERMISSIBLE _____

DATE _____

DISPENSE AS WRITTEN _____

DATE _____

IMPORTANT NOTICE: THIS FAX INTENDED TO BE DELIVERED ONLY TO THE NAMED ADDRESSEE AND CONTAINS CONFIDENTIAL INFORMATION THAT MAY BE PROTECTED HEALTH INFORMATION UNDER FEDERAL AND STATE LAWS. IF YOU ARE NOT INTENDED RECIPIENT, DO NOT DISSEMINATE, DISTRIBUTE, OR COPY THIS FAX. PLEASE NOTIFY THE SENDER IMMEDIATELY IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR AND THEN DESTROY THIS DOCUMENT IMMEDIATELY

OF PRESCRIPTIONS: _____