Hepatitis B Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Primary Phone: ______________ DOB: ______________

Alternate Phone: ______________ Gender: ☐Male ☐Female

Email address: ______________________________

Last 4 digits SS#: ______________

PRESCRIBER INFORMATION

Name: ______________________________

State License #: ______________ NPI #: ______________

DEA #: ______________________________

Address: ______________________________

City, State Zip: ______________________________

Phone: ______________ Fax: ______________

Contact Person: ______________ Phone: ______________

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

Medical Diagnosis / Clinical Information

Diagnosis: ☐ B19.10 Unspecified viral hepatitis B without hepatic come ☐ B19.11 Unspecified viral hepatitis B with hepatic come

Other: ______________

Previously treated with Interferon ☐Yes ☐No Start Date of Hepatitis B Therapy ______________

Pre-treatment ALT: __________ Date Drawn: __________ Most recent ALT: __________ DateDrawn: __________

Pre-treatment HBV Viral Load: ________ Date Drawn: ________ Liver biopsy done? ☐ Yes ☐No

Date of liver biopsy: __________ Results of liver biopsy: ______________

ANC: __________ /mm³ Date Drawn: ______________ Hgb: __________ g/dL Date Drawn: ______________

Prescription

THERAPY FOR HEPATITIS B

Drug	Strength	Directions	Quantity	Refills
☐ Hepsera	10mg	PO q Daily	30	
☐ Baraclude	☐0.5mg ☐1mg	PO q Daily	30	
☐ Viread	300mg	PO q Daily	30	
☐ Tyzeka	600mg	PO q Daily	30	
☐ Epivir-HBV	100mg	PO q Daily	30	
☐ Tenofovir	330mg	PO q Daily	180	
☐ L-carnitine	330mg	3 PO _______	☐180 ☐270	
☐ Pegasys ☐Vial ☐Proclick ☐Prefilled Syringe	☐135mcg ☐180mcg	☐ 180mcg SQ once weekly ☐ 135mcg SQ once weekly ☐ 90mcg SQ once weekly	28 day supply	
☐ Vemlidy	25mg	Once Daily	30	

Anticipated Start Date: ______________ **Physician Specialty:** ______________

Deliver to: Patient _____ **Physician Clinic** ______________________________

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: **Date**:

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.