HEPATITIS B

Toll free phone: 844.749.6628
Toll free fax: 855.516.3880

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber O˜ice ☐ Alternative Address:			

Prescriber Information

Practice Name:	O˜ice Contact:		
Prescriber :	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

ICD-10/Diagnosis : ☐ B18.1 (Chronic HBV) ☐ Other:		Does the patient have cirrhosis? ☐ No ☐ Compensated ☐ Decompensated	
Co-Infections: ☐ None ☐ HIV ☐ Hepatitis C		Has the patient been HBsAg positive for at least 6 months? ☐ Yes ☐ No	
Is the patient HBeAg positive? ☐ Yes ☐ No		Has the patient had a persistent serum ALT ≥ 2 times above upper limits of normal (ULN)? ☐ Yes ☐ No	
Prior Failed Therapy:			
Has the patient had a liver transplant? ☐ Yes ☐ No	Is the patient awaiting a liver transplant? ☐ Yes ☐ No	HBV DNA Level:	

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Baraclude® (entecavir)	☐ 0.5 mg tablet ☐ 1 mg tablet	Take one tablet by mouth daily without food	30	
☐ Vemlidy® (tenofovir alafenamide)	25 mg tablet	Take one tablet by mouth daily with food	30	
☐ Epivir-HBV® (lamivudine)	100 mg tablet	Take one tablet by mouth daily	30	
☐ Hepsera® (adefovir dipivoxil)	10 mg tablet	Take one tablet by mouth daily	30	
☐ Pegasys® (pegylated interferon)	☐ 180 mcg/0.5 mL PFS ☐ 180 mcg/0.5 mL vial ☐ 180 mcg/0.5 mL ProClick™	Inject 180 mcg sub-Q once weekly for 48 weeks	4 PFS	
☐ Viread® (tenofovir disoproxil fumarate)	300 mg tablet	Take one tablet by mouth daily	30	

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ Date _____

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