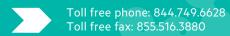


HEPATITIS B



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:	ne Number: Alternate Phone Num			ıber:		Language:		•			
Allergies (Required): □ NKD/			Height:		Weight:	SSN:					
Product Shipping Options: ☐ Patient's Home ☐ Pre	scriber (O~ice □ Alternat	ive Address	S:							
Prescriber Information											
Practice Name:				O~ice Contact:							
Prescriber:				ا	NPI:		D	DEA:			
Practice Address:				:		State:		Zip:			
Phone Number:				Fax Number:							
Clinical Information – Please send all available	able ch	art notes inclu	ding lab	results							
ICD-10/Diagnosis : ☐ B18.1 (Chronic HBV) ☐ Other: Does the patient have cirrhosis? ☐ No ☐ Compensated ☐ Decompensated										pensated	
Co-Infections: ☐ None ☐ HIV ☐ Hepatitis C Has the patient				been HBsAg positive for at least 6 months? 🔲 Yes 🗆 No							
Is the patient HBeAg positive? $\ \square$ Yes $\ \square$ No	he 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			vaiting a li	iver trans	splant? 🛚 Ye	s 🏻 No	HBV	DNA Level:			
Prescription Information											
Medication	Dose			Direction	ons				Quantity	Refills	
☐ Baraclude® (entecavir)	□ 0.5 □ 1 mg	mg tablet 1 tablet		Take one tablet by mouth daily w			v withou	ıt food			
\(\text{\constant}\)		, rabier			ne rabler by me		,		30		
☐ Vemlidy® (tenofovir alafenamide)	25 mg			Take or	ne tablet by mo				30 30		
☐ Epivir-HBV® (lamivudine)						outh dail	y with fo				
·	100 m	tablet		Take or	ne tablet by mo	outh dail	y with fo		30		
☐ Epivir-HBV® (lamivudine)	100 mg 10 mg	tablet g tablet		Take or	ne tablet by mo	outh dail	y with fo	pod	30 30		
☐ Epivir-HBV® (lamivudine) ☐ Hepsera® (adefovir dipivoxil)	100 mg 10 mg 180 180	tablet g tablet tablet mcg/0.5 mL PFS mcg/0.5 mL vial		Take or	ne tablet by mo	outh dail outh dail outh dail	y with for	pod	30 30 30		
☐ Epivir-HBV® (lamivudine) ☐ Hepsera® (adefovir dipivoxil) ☐ Pegasys® (pegylated interferon)	100 mg 10 mg 180 180 180 300 m	tablet g tablet tablet mcg/0.5 mL PFS mcg/0.5 mL vial mcg/0.5 mL Proc	Click™	Take or	ne tablet by mone tab	outh dail outh dail outh dail	y with for	pod	30 30 30 4 PFS		
☐ Epivir-HBV® (lamivudine) ☐ Hepsera® (adefovir dipivoxil) ☐ Pegasys® (pegylated interferon) ☐ Viread® (tenofovir disoproxil fumarate)	100 mg 10 mg 180 180 300 m GN Al	tablet g tablet tablet mcg/0.5 mL PFS mcg/0.5 mL vial mcg/0.5 mL Proc g tablet ND DATE BEL coact as my authorized a	OW) rigent to secure ript and submi	Take or Inject 18 Take or	ne tablet by mone tab	outh dail outh dail once we	y with for y thorization data includ	48 weeks	30 30 30 4 PFS 30	tance on	
☐ Epivir-HBV® (lamivudine) ☐ Hepsera® (adefovir dipivoxil) ☐ Pegasys® (pegylated interferon) ☐ Viread® (tenofovir disoproxil fumarate) PRESCRIBER SIGNATURE (PLEASE SI *Prescriber Authorization: I authorize this pharmacy and its repressibehalf as my authorized agent, including the receipt of any required behalf of my patients. If this pharmacy determines that it is unable the pharmacy of the patient's choice or in the patient's insurer's provide	100 mg 10 mg 180 180 300 m GN Al	tablet g tablet tablet mcg/0.5 mL PFS mcg/0.5 mL vial mcg/0.5 mL Proc g tablet ND DATE BEL o act as my authorized a orization forms, the rece prescription, I further a	OW) rigent to secure ript and submi	Take or Inject 18 Take or	ne tablet by mone tab	outh dail outh dail once we	y with for y thorization data includ	48 weeks	30 30 30 4 PFS 30	tance on	

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Date