

For assistance, contact your pharmacy representative: \_\_\_\_\_ Phone: \_\_\_\_\_ (For providers only)

**PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



**Hepatitis B**  
Prescription/Pharmacy Intake Form

Central Pharmacy: \_\_\_\_\_  
 Retail/Community Pharmacy Fax: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
**Date Needed:** \_\_\_\_\_ **Ship To:**  Prescriber's Office  Patient's Home  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
Insurance provider (Please include copy of front and back of card): \_\_\_\_\_  
ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  Patient is eligible for Medicare

**CLINICAL ASSESSMENT Please complete ALL sections to avoid delays in filling prescription**

Diagnosis: \_\_\_\_\_ ICD 10: \_\_\_\_\_ Previously treated with interferon?  Yes  No Start date of Hepatitis B therapy: \_\_\_\_\_  
Pre-treatment HBV viral load: \_\_\_\_\_ Date: \_\_\_\_\_ Liver Biopsy results: \_\_\_\_\_ Date: \_\_\_\_\_  
ANC: \_\_\_\_\_ mm3 Date: \_\_\_\_\_ Hgb: \_\_\_\_\_ g/dL Date: \_\_\_\_\_  
Pre-treatment ALT: \_\_\_\_\_ Date: \_\_\_\_\_ Most recent ALT: \_\_\_\_\_ Date: \_\_\_\_\_  
Serologies: e-antigen HBeAg+ \_\_\_\_\_ e-antigen HBeAg- \_\_\_\_\_ Weight: \_\_\_\_\_  
Prior Therapy: \_\_\_\_\_ Approximate Start Date: \_\_\_\_\_  
Reasons for Discontinuation: \_\_\_\_\_ Approximate End Date: \_\_\_\_\_  
Fibrosis Score:  F<sub>0</sub>  F<sub>1</sub>  F<sub>2</sub>  F<sub>3</sub>  F<sub>4</sub> Cirrhosis:  None  Compensated  Decompensated Transplant Status:  N/A  Awaiting Transplant  Post Transplant  
Other Health Conditions, Allergies, Concomitant Medications: \_\_\_\_\_  
Please indicate what, if any, documents to assist with prior authorizations are attached: \_\_\_\_\_

Medication	Dose/Directions/Frequency	Qty	Refills
<input type="checkbox"/> Baraclude <input type="checkbox"/> 0.5mg tablet <input type="checkbox"/> 1mg tablet <input type="checkbox"/> 0.05mg/ml oral solution			
<input type="checkbox"/> Epivir HBV <input type="checkbox"/> 100mg tablet <input type="checkbox"/> 5mg/ml oral solution			
<input type="checkbox"/> Hepsera <input type="checkbox"/> 10mg tablet			
<input type="checkbox"/> Pegasys <input type="checkbox"/> 180mcg/mL Vial <input type="checkbox"/> 180mcg/0.5 mL Prefilled Syringe <input type="checkbox"/> 180mcg/0.5 mL Autoinjector <input type="checkbox"/> 135mcg/0.5 mL Autoinjector			
<input type="checkbox"/> Vemlidy 25mg tablet			
<input type="checkbox"/> Viread 300mg tablet			

**PRESCRIBER INFORMATION**

Prescriber's name: \_\_\_\_\_ Practice/facility: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Office contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Best time to call: \_\_\_\_\_ Preferred method of contact:  Email  Phone  Fax  
State license #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

\_\_\_\_\_ Dispense as written \_\_\_\_\_ Substitution permitted \_\_\_\_\_ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.