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)**.

Walgreens | allianceRx Walgreens + PRIME

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_0 ☐F_1 ☐F_2 ☐F_3 ☐F_4 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
☐Baraclude ☐0.5mg tablet ☐1mg tablet ☐0.05mg/ml oral solution			
☐Epivir HBV ☐100mg tablet ☐5mg/ml oral solution			
☐Hepsera ☐10mg tablet			
☐Pegasys ☐180mcg/mL Vial ☐180mcg/0.5 mL Prefilled Syringe ☐180mcg/0.5 mL Autoinjector ☐135mcg/0.5 mL Autoinjector			
☐Vemlidy 25mg tablet			
☐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.