Hepatitis B Enrollment Form

PRx

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

HEPBRX-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ B18.0 Hepatitis B (with delta agent)
☐ B18.1 Hepatitis B (without delta agent)
☐ Other: _____

Coinfections:
☐ HIV ☐ HEPC

Please list previously tried/failed therapies and dates:

Viral Load: _____ Date: ____ /____ / ____

Liver Biopsy: ☐ Yes ☐ No Result: _____

Pre-treatment ALT: _____ Date: ____ /____ / ____
Current ALT: _____ Date: ____ /____ / ____
ANC: _____ Date: ____ /____ / ____
Hbg: _____ Date: ____ /____ / ____
PLT: _____ Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Baraclude®** (entecavir)	☐ 0.5 mg tablets ☐ 1 mg tablets	☐ Take one tablet by mouth once daily on an empty stomach		
☐ **Epivir-HBV®** (lamivudine)	☐ 100 mg tablets	☐ Take one tablet by mouth once daily		
☐ **Hepsera®** (adefovir dipivoxil)	☐ 10 mg tablets	☐ Take one tablet by mouth once daily		
☐ **Pegasys®** (peginterferon alfa-2a)	☐ ProClick 135 mcg ☐ ProClick 180 mcg ☐ Prefilled syringe 180 mcg ☐ Vial 180 mcg	☐ Inject 180 mcg subcutaneously once weekly ☐ Inject 135 mcg subcutaneously once weekly (indicated with CrCl <30 mL/minute or dialysis)		
☐ **Vemlidy®** (tenofovir alafenamide)	☐ 25 mg tablets	☐ Take one tablet by mouth once daily with food		
☐ **Viread®** (tenofovir disoproxil fumarate)	☐ 300 mg tablets	☐ Take one tablet by mouth once daily ☐ Other: _____		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: _____ / _____ / _____