

Hepatitis B



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information		Prescriber + Shipping Information	
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____		Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never	
Please fax a copy of front and back of the insurance card (s).			
Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> B18.0 Hepatitis B (with delta agent) <input type="checkbox"/> B18.1 Hepatitis B (without delta agent) <input type="checkbox"/> Other: _____ Pre-treatment HBV viral load: _____ Date: _____ ANC: _____ /mm ³ Date: _____ Hgb: _____ g/dL Date: _____ Liver Biopsy: <input type="checkbox"/> Yes <input type="checkbox"/> No Biopsy Results: _____ Date: _____ Pre-treatment ALT: _____ Date: _____ Most recent ALT: _____ Date: _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____	Reason for Discontinuation of Therapy _____ _____ _____	Approximate Start Date _____ _____ _____	Approximate End Date _____ _____ _____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			
Prescription	Quantity	Refill	
<input type="checkbox"/> Hepsera® (adefovir dipivoxil)	Take 10 mg by mouth once daily _____	30 x 10 mg tablets _____	
<input type="checkbox"/> Baraclude® (entecavir)	Take 0.5 mg by mouth once daily on an empty stomach Take 1 mg by mouth once daily on an empty stomach _____	30 x 0.5 mg tablets 30 x 1 mg tablets _____	
Epivir-HBV® (lamivudine)	Take 100 mg by mouth once daily	30 x 100 mg tablets _____	
Viread® (tenofovir disoproxil fumarate)	Take 300 mg by mouth once daily	30 x 300 mg tablets _____	
Vemlidy® (tenofovir alafenamide)	Take 25 mg by mouth once daily with food	30 x 25 mg tablets _____	
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____			
<i>Stamp signature not allowed, physician signature required.</i>			
Prescriber's Signature: _____		Date: _____	
I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Thrifty White Specialty Pharmacy.			

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