Hepatitis B

Employee Owned
Thrifty White PHARMACY
Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____☐cm ☐in
Address: _____
Apt/Suite:_____ City: _____ State: _____ Zip:_____
Phone:_____ Alternate: _____
Caregiver name: _____ Relation:_____
Local pharmacy: _____ Phone: _____
Insurance plan: _____Plan ID:_____
Please fax a copy of front and back of the insurance card (s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax:_____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ B18.0 Hepatitis B (with delta agent) ☐ B18.1 Hepatitis B (without delta agent) ☐Other: _____
Pre-treatment HBV viral load: _____ **Date:** _____
ANC: _____/mm³ **Date:** _____ **Hgb:** _____g/dL **Date:** _____
Liver Biopsy: ☐ Yes ☐No **Biopsy Results:** _____ **Date:** _____
Pre-treatment ALT: _____ **Date:** _____ **Most recent ALT:** _____ **Date:** _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐NKDA ☐ Other: _____

Prescription		Quantity	Refill
☐ **Hepsera®** **(adefovir dipivoxil)**	☐ Take 10 mg by mouth once daily ☐ _____	☐ 30 x 10 mg tablets ☐ _____	_____
☐ **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: _____

Stamp signature not allowed, physician signature required.

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.

Reset Form