

## Patient Information

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State	ZIP
Shipping Address (if different from above)				City		State	ZIP
Social Security Number		Gender (M/F)	Weight/Recorded Date	Date of Birth	Allergies		
Emergency Contact		Phone		Primary Caregiver		Phone	

## Healthcare Provider Information:

Practice/Facility Name			Physician Name			Phone/Fax	
Address				City		State	ZIP
Physician NPI #		Nurse/Key Contact		Phone or Pager Number		Email	

## Diagnosis/Clinical Information:

B18.0 Chronic HBV  
  B18.0 Chronic HBV with delta-agent  
  B18.1 Chronic HBV w/o delta-agent  
 Co-infected with HIV? Yes  No   
 HBV Viral Load: \_\_\_\_\_ Copies/mL: \_\_\_\_\_ Date: \_\_\_\_\_  
 Current SCR: \_\_\_\_\_ Date: \_\_\_\_\_  
 LFTs test:  ALT \_\_\_\_\_ Units/L  
 Other: \_\_\_\_\_ Date: \_\_\_\_\_  
 Cirrhosis:  Yes ( Compensated  Decompensated)  No  
 Liver Biopsy:  No  Yes  
 Result: \_\_\_\_\_  
 Has patient been treated previously for this condition?  No  Yes  
 Medication(s): \_\_\_\_\_  
 Is patient currently on therapy?  No  Yes  
 Medication(s): \_\_\_\_\_  
 \_\_\_\_\_  
 Will patient stop taking the above medication(s) before starting the new medication?  No  Yes (if yes, what is the washout period?) \_\_\_\_\_  
 Other medications patient is currently taking including OTC medications (or fax medication profile): \_\_\_\_\_  
 \_\_\_\_\_

## Delivery Information:

Patient Home  
  MD Office  
  Other: \_\_\_\_\_

Medication	Dose/Directions	Quantity	Refills
<input type="checkbox"/> <b>Hepsera®</b> (adefovir dipivoxil)	<input type="checkbox"/> Take 10 mg by mouth once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> <b>Baraclude®</b> (entecavir)	<input type="checkbox"/> Take 0.5 mg by mouth once daily on an empty stomach <input type="checkbox"/> Take 1 mg by mouth once daily on an empty stomach <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> <b>Epivir/Epivir-HBV®</b> (lamivudine)	<input type="checkbox"/> Epivir   Take 100 mg by mouth once daily <input type="checkbox"/> Epivir-HBV   150mg po BID (only for co-infected patient with HIV) #60 <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> <b>Viread®</b> (tenofovir disoproxil fumarate)	<input type="checkbox"/> Take 300 mg by mouth once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> <b>Vemlidy®</b> (tenofovir alafenamide)	<input type="checkbox"/> Take 25 mg by mouth once daily with food <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____	_____

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 to prohibit substitution:

**PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED**

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) \_\_\_\_\_

DISPENSE AS WRITTEN/Do Not Substitute (date) \_\_\_\_\_

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