HEPATITIS B ENROLLMENT FORM

Phone: (813) 871-5161 ext. 34993
Fax: (813) 877-2479

PATIENT INFORMTION (OR ATTACH PATIENT DEMOGRAPHIC SHEET)			
Patient Name:	☐Male ☐Female	Allergies: ☐NKDA	
Date of Birth:	SSN:	Weight: ☐kg ☐lb	Date:
Address:	City:	State:	Zip:
Phone # (Home):	Work #:	Email (Optional):	
INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)			
Primary Insurance:	RX Bin:	RX PCN:	
RX Group:	RX ID:	RX Phone:	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SSN:	
DIAGNOSIS/MEDICAL INFORMATION (COMPLETE CLINICAL INFO BELOW OR ATTACH PATIENTS LABS)			
Diagnosis: ☐ B18.0 Hepatitis B (with delta agent)	☐ B18.1 Hepatitis B (without delta agent)	☐ Other ICD-10:	
HBV DNA Viral Load:	IU/mL:	Date:	
Complete Metabolic Panel:	Date:		
HIV-1 ½ Antibody Test:	Date:		
Is this a continuation of treatment? ☐ Yes ☐ No			
If yes, what is the patient's current treatment?			

PRESCRIPTION INFORMATION				
MEDICATION	**DOSE**	**DIRECTIONS**	**QTY**	**REFILLS**
☐ Baraclude® (*entecavir*)	☐ 0.5 mg tablet ☐ 1 mg tablet	☐ Take one tablet by mouth once a day on empty stomach	30	
☐ Epivir® – HBV (*lamivudine*)	☐ 100 mg tablet	☐ Take one tablet by mouth once a day	30	
☐ Viread® (*tenofovir disoproxil fumarate*)	☐ 300 mg tablet	☐ Take one tablet by mouth once a day	30	
☐ Vemlidy® (*tenofovir alafenamide*)	☐ 25 mg tablet	☐ Take one tablet by mouth once a day with food	30	

DELIVERY INSTRUCTIONS		
☐ Physician's Office	☐ Patient's Home	☐ 1st dose MD office, Refills to patient's home
PHYSICIANS CONTACT INFORMATION & AUTHORIZATION		
Physician's Name:	Office Contact:	Institution:
Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:		Date:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document. Created:08/28/18 Revised: 05/01/19, 08/22/19, 02/24/20