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| --- |
| Attention:                                     Need By Date:                 First Ship To: [ ]  Patient [ ]  Physician |
| **Patient** | Patient Name:                                    DOB:                 Sex: [ ]  Male [ ]  Female Address:                                     City:                      State:                 Zip:           Home#:                 Work #:                 Cell#:                 Best time to call: [ ]  AM [ ]  PMSoc. Sec #:           -          -           Ethnicity:                 Primary Language:                Comorbidities:                      Height:            Weight:           Date:          Allergies:                                                              [ ]  NKDA |
| **Provider** | Physician Name:                     Practice Name:                State Lic#:            DEA#:           Address:                          City:                State:           Zip:           NPI#:           Phone#:                 Fax#:                 Nurse/Key Office Contact:                 Ext.:            |
| **Insurance** | Primary Insurance:                      ID:                      Phone:                     Secondary Insurance:                      ID:                      Phone:                     \* Please provide a copy of the insurance card (front and back) and MEDICATION LIST |
| **Clinical Info** | **Current medications** (if necessary, please fax copy of complete list):                                                              |
| **Diagnosis/ICD-10:** B16.2 Hepatitis B B16.9 Hepatitis Other:                                                             |
| **Previously treated with interferon? ( [ ]  Y [ ]  N )** | **Pre-treatment HBV viral load:**                 date:            |
| Start date of hep B therapy:                                     | **ANC:**                          /mm3      date:            |
| Pre-treatment ALT:                           date:            | **Liver biopsy: (** [ ]  **Y /** [ ]  **N ) results:**            date:            |
| Most recent ALT:                           date:            | **Hgb:**                          g/dL       date:            |
| **Prescription** |
| **Medication** | **Strength** | **Directions** | **Quantity** | **Refill** |
| **[ ]  Baraclude®** |  0.5 mg/1 mg | Take 1 tablet by mouth once daily  | 30 days supply |       |
| **[ ]  Epivir HBV®** | **[ ]** 100 mg tablet**[ ]** 5 mg/ml oral solution | Take 1 tablet by mouth once daily                               | 30 days supply |       |
| **[ ]  Hepsera®** |  10 mg | Take 1 tablet by mouth once daily  | 30 days supply |       |
| **[ ]  Tyzeka®** |  600mg | Take 1 tablet by mouth once daily  | 30 days supply |       |
| **[ ]  Viread®** |  300mg | Take 1 tablet by mouth once daily  | 30 days supply |       |
| **[ ]  Other** |                |                                |       |       |
| Physicians Signature:                                Date:                I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. |