|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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  PM  Soc. 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. | | | | | | |