

HEPATITIS B PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
 1636 Miller Park Way, West Milwaukee, WI 53214
 Phone: 414-385-9500 Fax: 414-385-7200
 www.altscripts.com



Patient Information: please provide a copy of the patient's insurance card or information

Patient Name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:		City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:		Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:					

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:		Viral Load/Date:		Fibrosis Score:
HBeAg: +/-	HBsAg: +/- (+ since ___/___/___)	ALT:	SrCr:	
Moderate to severe active necroinflammation: Y / N		Prior Therapies:		
<input type="checkbox"/> Patient is currently on therapy (Start date ___/___/___)				

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Baraclude®	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily		
<input type="checkbox"/> Epivir®	<input type="checkbox"/> 100 mg			
<input type="checkbox"/> Hepsara®	<input type="checkbox"/> 10 mg			
<input type="checkbox"/> Tyzeka®	<input type="checkbox"/> 600 mg			
<input type="checkbox"/> Viread®	<input type="checkbox"/> 300 mg			
<input type="checkbox"/> Vemlidy®	<input type="checkbox"/> 25 mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily with food		
<input type="checkbox"/> Pegasys®	<input type="checkbox"/> 180 mcg/ vial <input type="checkbox"/> 180 mcg/ 0.5 ml <input type="checkbox"/> PFV <input type="checkbox"/> autojector <input type="checkbox"/> 135 mcg/ 0.5 ml autojector	<input type="checkbox"/> Inject SQ once weekly		

Physician Information

Prescriber name:		Phone:	Office contact name:	
Prescriber address:		City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:		
Prescriber signature:		Date:	<input type="checkbox"/> DO NOT SUBSTITUTE	

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