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:** ☐ F ☐ M	**HT:**	**WT:**	
Address:	**City:**	**State:**	**Zip Code:**	**Phone:**	
Insurance:	**Subscriber's name:**	**ID#:**	**Group #:**		
Allergies: ☐ NKDA ☐ 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:**		
□ **Patient is currently on therapy** (Start date ____/_____/_____)			

Medication	**Dose / Strength**	**Directions**	**Quantity**	**Refills**
☐ **Baraclude®**	□ 0.5 mg □ 1 mg	□ Take 1 tablet by mouth once daily		
☐ **Epivir®**	□ 100 mg			
☐ **Hepsera®**	□ 10 mg			
☐ **Tyzeka®**	□ 600 mg			
☐ **Viread®**	□ 300 mg			
☐ **Vemlidy®**	□ 25 mg tablet	□ Take 1 tablet by mouth once daily with food		
☐ **Pegasys®**	□ 180 mcg/ vial □ 180 mcg/ 0.5 ml □ PFV □ autojector □ 135 mcg/ 0.5 ml autojector	☐ 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:**	□ **DO NOT SUBSTITUTE**		