Hepatitis B

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient Information

patient: ______________________ male / female DOB: __________ SS#: __________
last name, first name

address: ______________________
street city state zip

primary phone number: __________ cell alternate phone number: __________ cell

caregiver: __________ allergies: __________ NKDA

comorbidities: __________ height: ______ weight: ______ lbs / kg date: __________

Clinical Information

Current medications (if necessary, please fax copy of complete list): __________

Diagnosis/ICD-9: 070.20 Hepatitis B 070.30 Hepatitis B other: __________

Previously treated with interferon? (Y / N)

Start date of hep B therapy: __________

Pre-treatment ALT: __________ date: ______

Most recent ALT: __________ date: ______

Pre-treatment HBV viral load: __________ date: ______

ANC: __________ $/mm^3$ date: ______

Liver biopsy: (Y / N) **results:** __________ date: ______

Hgb: __________ g/dL date: ______

Prescription	Strength	Directions	Quantity	Refills
Hepsera®	10 mg	Take 1 tablet by mouth once daily	30	
Baraclude®	0.5 mg 1 mg	Take 1 tablet by mouth once daily	30	
Tyzeka®	600 mg	Take 1 tablet by mouth once daily	30	
Epivir-HBV®	100 mg	Take 1 tablet by mouth once daily	30	
Viread®	300 mg	Take 1 tablet by mouth once daily	30	

Prescriber + Shipping information

prescriber (print): __________ office contact: __________

preferred method of contact: phone fax email preferred contact persons email: __________

ship to: patient office alternate __________
shipping address: street city state zip

office address: __________
(street, suite, city, state, zip)

phone: __________ fax: __________ NPI: __________ DEA: __________

prescriber's signature: __________ date: __________

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

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