ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

HEPATITIS B ENROLLMENT FORM

PATIENT INFORMATION

NAME:	**DOB:**	**PHONE:**
ADDRESS:		**SSN:**
Insurance Company:	**ID#**	**Group#:**

CLINICAL INFORMATION

Current Medications:

Diagnosis/ICD-10:
- ☐ B16.2 Acute hepatitis B without delta-agent with hepatic coma
- ☐ B16.9 Acute hepatitis B without delta-agent without hepatic coma
- ☐ B19.10 Unspecified viral hepatitis B without hepatic coma
- ☐ B19.11 Unspecified viral hepatitis B with hepatic coma

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:

PRIOR AUTHORIZATION CHECKLIST (PLEASE INCLUDE)

☐ **Viral Load**	☐ **CBC**
☐ **CMP**	☐ **Chart Notes**
☐ **Liver Staging Documentation (if available)**	☐ **Copy of insurance card**

PRESCRIPTION INFORMATION

Hepsera: ☐ **10 mg**
(adefovir)
Sig: Take 1 tablet by mouth once daily
Qty: 30 Refills: ____

Baraclude: ☐ **0.5 mg** ☐ **1 mg**
(entecavir)
Sig: Take 1 tablet by mouth once daily
Qty: 30 Refills: ____

Tyzeka: ☐ **600 mg**
(telbivudine)
Sig: Take 1 tablet by mouth once daily
Qty: 30 Refills ____

Epivir-HBV: ☐ **100 mg**
(lamivudine)
Sig: Take 1 tablet by mouth once daily
Qty: 30 Refills: ____

Viread: ☐ **300 mg**
(tenofovir disoproxil fumarate)
Sig: Take 1 tablet by mouth once daily
Qty: 30 Refills: ____

Vemlidy: ☐ **25 mg**
(tenofovir alafenamide)
Sig: Take 1 tablet by mouth once daily with food
Qty: 30 Refills: ____

☐ Patient is ready to start treatment, contact patient for delivery ☐ Ship all orders to office ☐ Ship first order to office, subsequent orders to patient

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified