

**Deliver to:**  Patient's Home  Prescriber's Office  Other: \_\_\_\_\_  Hold shipment until notified by prescriber  Anticipated Start Date: \_\_\_\_\_

### 1. Patient Information

Last Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work / Mobile Phone: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
 S.S. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Guardian / Caregiver: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lb  kg

### 2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Prescription Card: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ BIN / PCN: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

### 3. Prescriber Information

Prescriber Name: \_\_\_\_\_  MD  DO  NP  PA License #: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Collaborating Physician: \_\_\_\_\_

### 4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: \_\_\_\_\_ Secondary ICD-10: \_\_\_\_\_ HBsAG Result\*: Value: \_\_\_\_\_ Date: \_\_\_\_\_  
 Concurrent Medications: \_\_\_\_\_ Serum HBV RNA\*: Value: \_\_\_\_\_ Date: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ ALT: \_\_\_\_\_ Date: \_\_\_\_\_ AST: \_\_\_\_\_ Date: \_\_\_\_\_  
 Meds Tried / Failed: \_\_\_\_\_ \*Please include a copy of the patient's most recent lab results.

### 5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
BARACLUDE®	<input type="checkbox"/> 0.5 mg tabs <input type="checkbox"/> 1 mg tabs <input type="checkbox"/> 0.05 mg/mL <input type="checkbox"/> Oral Solution	<input type="checkbox"/> 0.5 mg PO QD <input type="checkbox"/> 1mg PO QD <input type="checkbox"/> _____ mg PO QD		
EPIVIR-HBV	<input type="checkbox"/> 100 mg tabs <input type="checkbox"/> 5 mg/mL Oral Solution	<input type="checkbox"/> 100 mg PO QD <input type="checkbox"/> _____ mg PO QD		
HEPSERA®	<input type="checkbox"/> 10 mg tabs	• 10 mg PO QD		
PEGASYS®	<input type="checkbox"/> 180 mcg/mL SDV <input type="checkbox"/> 180 mcg/0.5 mL PFS	<input type="checkbox"/> Inject 180 mcg SC QW x _____ weeks <input type="checkbox"/> Other: _____		
VEMLIDY®	<input type="checkbox"/> 25 mg tabs	• 25 mg PO QD with food		
VIREAD®	<input type="checkbox"/> 150 mg tabs <input type="checkbox"/> 200 mg tabs <input type="checkbox"/> 250 mg tabs <input type="checkbox"/> 300 mg tabs <input type="checkbox"/> 40 mg / 1g Oral Powder	<input type="checkbox"/> 300 mg PO QD <input type="checkbox"/> Other: _____		
Hepatitis B Immune Globulin	<input type="checkbox"/> NABI-HB® <input type="checkbox"/> HyperHEP B® S/D <input type="checkbox"/> HEPAGAM B®			
<input type="checkbox"/>				

**Patient Support Programs:** Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Account Manager**

\_\_\_\_\_

### Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible \_\_\_\_\_ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Prescriber Signature-Dispense as Written \_\_\_\_\_ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_