HEPATITIS B **ENROLLMENT FORM**

Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name ______________________

DOB ______________ Last Four of SS# ______________

Gender: ○ M ○ F ○ (Childbearing) Height: __________ in Weight: __________ lb

Home Address ______________________

City ______________________

State ______________ Zip ______________

Home Phone ______________ Work Phone ______________

Email ______________________

Preferred method of contact ○ Phone ○ Email ○ Text ○ Other: ______________

Allergies: ______________________

Medications: ______________________

Prescriber Information

Prescriber's Name ______________________

Clinic/Hospital Affiliation ______________________

Address ______________________

City ______________________

State ______________ Zip ______________

Phone ______________________

Fax ______________________

Contact Person ______________________

License # ______________________

NPI # ______________________

Medicaid Provider # ______________________

Medical Information: Section must be completed to process prescription. (Attach separate sheet is needed)

Diagnosis

○ B18.0 Hepatitis B (with delta agent) ○ B18.1 Hepatitis B (without delta agent) ○ Other ______________

Previously treated with interferon ○ Yes ○ No

Pre-treatment ALT ______________ Date: ______________ Current ALT ______________ Date: ______________

ANC: ______________ /mm3 Date ______________ Hbg: g/dL ______________ Date ______________

Pre-treatment HBV viral load ______________ Date: ______________

Liver biopsy ○ Yes ○ No Results ______________________

Prescription Information

Medication	Dose/Strength	Direction	Quantity	Refills
○ Baraclude®	○ 0.5 mg	Take one by mouth once daily		
	○ 1 mg			
	○ 0.05 mg / mL			
○ Epivir HBV	○ 100 mg	Take one by mouth once daily		
○ Hepsera®	○ 10 mg	Take one by mouth once daily		
○ HBIG				
○ Pegasys®	○ ProClick 180 mcg	Autoinjector SQ once weekly		
	○ ProClick 135 mcg	Autoinjector SQ once weekly		
	○ Pre-Filled Syringe 180 mcg/0.5 mL, 180 mcg	SQ once weekly		
	○ Pre-Filled Syringe 180 mcg/0.5 mL, 135 mcg	SQ once weekly		
○ Peg-Intron®	○ 50 mcg (0.5 mL)	SQ once weekly		
	○ 96 mcg (0.4 mL)	SQ once weekly		
	○ 64 mcg (0.4 mL)	SQ once weekly		
	○ 120 mcg (0.5 mL)	SQ once weekly		
	○ 80 mcg (0.5 mL)	SQ once weekly		
	○ 150 mcg (0.5 mL)	SQ once weekly		
○ Tyzeka®	○ 600 mg	Take one by mouth once daily		
○ Viread®	○ 300 mg	Take one by mouth once daily		

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** ______________ ***Date*** ______________ ***Needs by Date*** ______________

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: ______________________ ______________________ ***Date:*** ______________

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: ______________________

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