HEPATITIS B
Enrollment Form

FAX: 1-855-322-2087
PHONE: 1-855-443-9944
NPI: 1417216128

Deliver Medications To: Patient's Home Doctor's Office Date Needed By: ___________ Inj. Training/Admin. Y N

PATIENT DEMOGRAPHICS

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD

Primary Prescription Insurance: ______________________ Rx BIN: ____________ Rx PCN #: ____________

Patient ID/Policy Number: ______________________ Patient Rx Group Number: ______________________

PATIENT CLINICAL INFORMATION/HISTORY: (PLEASE ATTACH A COPY OF PATIENT'S RECENT CHART NOTES, PATHOLOGY AND LABS)

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

Diagnosis/ICD-10: B18.0 Hepatitis B B18.1 Hepatitis B Other: ______________________

Previously treated with Interferon? Y N

Pre-treatment HBV viral load: ______________________

Start date of Hep B therapy: ______________________

ANC: ______________________

Pre-treatment ALT: ______________________

Liver biopsy: Y N ______________________

Most recent ALT: ______________________

Hgb: ______________________

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Baraclude	0.5mg 1.0mg	Take one tablet by mouth once daily	30	
Epivir-HBV	100mg	Take one tablet by mouth once daily	30	
Hepsera	10mg	Take one tablet by mouth once daily	30	
Tyzeka	600mg	Take one tablet by mouth once daily	30	
Vemlidy	25mg	Take one tablet by mouth once daily	30	
Viread	300mg	Take one tablet by mouth once daily	30	

PRESCRIBER INFORMATION

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: Office Fax: Office Contact:

DEA: NPI: UPIN:

Physician Signature: ______________________ Date: ______________________

"By signing I hereby authorize Encompass Rx, LLC and its pharmacists, technicians and other employees and agents to disclose, share and submit patient information to health insurers, HMOs, employer group health plans, governmental health programs, or other payors, for the purposes of satisfying such payor's prior authorization requirements with respect to the medication being prescribed for the treatment of our mutual patient."