MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

HEP-B

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:		Pcn:	RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ HEPSERA (adefovir)	☐ 10MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ BARACLUDE (entecavir)	☐ .05MG/ML ORAL SOLUTION ☐ 0.5MG TABLET ☐ 1MG TABLET	☐ TAKE 1 CAPSULE BY MOUTH ONCE DAILY ON AN EMPTY STOMACH ☐ OTHER: _____		
☐ EPIVIR	☐ 150MG TABLET ☐ 300MG TABLET	☐ TAKE 1 CAPSULE BY MOUTH TWICE DAILY ☐ TAKE 1 CAPSULE BY MOUTH ONCE DAILY	[30] OR [60]	
☐ EPIVIR-HBV (lamivudine)	☐ 10MG/ML ORAL SOLUTION ☐ 100MG TABLET	☐ TAKE 1 CAPSULE BY MOUTH ONCE DAILY ☐ OTHER: _____		
☐ VIREAD (tenofovir disoproxil fumarate)	☐ 40MG/SCOOP POWDER ☐ 150MG TABLET ☐ 200MG TABLET ☐ 250MG TABLET ☐ 300MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY ☐ OTHER: _____		
☐ VEMLIDY (tenofovir alafenamide)	☐ 25MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY WITH FOOD	[30]	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

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Please fax completed form to 1 (855) 595-2955