MedBox

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HEPATITIS B ENROLLMENT FORM

Patient Information – *Please attach a copy of the patient's insurance card*

Patient Name: | Date of Birth: | ♣ Male ♣ Female

Address: | City: | State: | Zip:

Phone Number: | Alternate Phone Number: | Language:

Allergies (Required): ♣ NKDA | Height: | Weight: | SSN:

Product Shipping Options: ♣ Patient's Home ♣ Prescriber Office ♣ Alternative Address:

Prescriber Information

Practice Name: | Office Contact:

Prescriber: | NPI: | DEA:

Practice Address: | City: | State: | Zip:

Phone Number: | Fax Number:

Prescriber Primary Specialty: ♣ Pain ♣ Addiction ♣ Rehabilitation ♣ Other:

Clinical Information – *Please send all available chart notes including lab results*

ICD-10/Diagnosis: ♣ B18.1 (Chronic HBV) ♣ Other: | Does the patient have cirrhosis? ♣ No ♣ Compensated ♣ Decompensated

Co-Infections: ♣ None ♣ HIV ♣ Hepatitis C | Has the patient been HBsAg positive for at least 6 months? ♣ Yes ♣ No

Is the patient HBeAg positive? ♣ Yes ♣ No | Has the patient had a persistent serum ALT > 2 times above upper limits of normal (ULN)? ♣ Yes ♣ No

Prior Failed Therapy:

Has the patient had a liver transplant? ♣ Yes ♣ No | Is the patient awaiting a liver transplant? ♣ Yes ♣ No | HBV DNA Level:

Prescription Information

Medication	Dose	Directions	Quantity	Refills
♣ Baraclude® *(entecavir)*	♣ 0.5 mg tablet ♣ 1 mg tablet	Take one tablet by mouth daily without food	30	
♣ Vemlidy® *(tenofovir alafenamide)*	25 mg tablet	Take one tablet by mouth daily with food	30	
♣ Epivir-HBV® *(lamivudine)*	100 mg tablet	Take one tablet by mouth daily	30	
♣ Hepsera® *(adefovir dipivoxil)*	10 mg tablet	Take one tablet by mouth daily	30	
♣ Pegasys® *(pegylated interferon)*	♣ 180 mcg/0.5 mL PFS ♣ 180 mcg/0.5 mL vial ♣ 180 mcg/0.5 mL ProClick™	Inject 180 mcg sub-Q once weekly for 48 weeks	4 PFS	
♣ Viread® *(tenofovir disoproxil fumarate)*	300 mg tablet	Take one tablet by mouth daily	30	

Prescriber Signature and Date (Please sign and date below)

Dispense as Written ______ Date | Substitution Permissible ______ Date

♣ Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"

Important Notice: This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. This transmission may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents.

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.