HOME PARENTERAL SERVICES

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Hepatitis B

patient information

patient: ______________________ male female DOB: __________ SS#: __________
last name, first name

address: ____
street city state zip

primary phone number: __________ cell alternate phone number: __________ cell

caregiver: __________ allergies: __________ NKDA

comorbidities: __________ height: __________ weight: __________ lbs kg date: __________

clinical information

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

Diagnosis/ICD-10: other: __________

Previously treated with interferon? (Y / N)

Start date of hep B therapy: __________

Pre-treatment ALT: __________ date: __________

Most recent ALT: __________ date: __________

Pre-treatment HBV viral load: __________ date: __________

ANC: __________ /mm^3 date: __________

Liver biopsy: (Y / N) results: __________ date: __________

Hgb: __________ g/dL date: __________

prescription	strength	directions	quantity	refills
Hepsera	10 mg	Take 1 tablet by mouth once daily	30	
Baraclude	0.5 mg 1 mg	Take 1 tablet by mouth once daily	30	
Tyzeka	600 mg	Take 1 tablet by mouth once daily	30	
Epivir-HBV	100 mg	Take 1 tablet by mouth once daily	30	
Viread	300 mg	Take 1 tablet by mouth once daily	30	

prescriber + shipping information

prescriber (print): __________ office contact: __________

preferred method of contact: phone fax email preferred contact persons email: __________

ship to: patient office alternate __________
shipping address: street city state zip

office address: __________
(street, suite, city, state, zip)

phone: __________ fax: __________ NPI: __________ DEA: __________

prescriber's signature: __________ date: __________

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)

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