CoxHealth at Home

PHONE: 1-855-419-4663
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: ______

To order an Hepatitis B medication, please either fill out the prescription below OR fax a seperate prescription with this referral form

Drug/Dose/Route/Frequency: ______________________________

____

____

Quantity to Dispense: __________

Refills: ______

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 CoxHealth at Home 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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