Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

HEPATITIS B ENROLLMENT

Patient Information

Patient SS#:_____ DOB:_____ ☐ Male ☐ Female
Patient First Name:_____ Patient Last Name:_____ Caregiver:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell
Email:_____ Weight:_____ kgs or lbs (circle one) Recorded Date:_____
Allergies:_____ Comorbidities:_____
Current Medications *(if necessary, please fax copy of complete list)*:_____

Insurance Information

Fill out entirely OR **fax copy of patient's insurance card - both sides**

Primary Insurance:_____ Secondary Insurance:_____
Insured:_____ Insured:_____
Phone:_____ Phone:_____
Policy #:_____ Policy #:_____
RxBIN:_____ RxPCN:_____ RxBIN:_____ RxPCN:_____

Medical Assessment

Diagnosis: ☐ 070.2 Hepatitis B ☐ 070.3 Hepatitis B ☐ Other:_____
Previously treated with Interferon ☐ Yes ☐ No
Start Date of Hepatitis B Therapy:_____
Pre-treatment ALT:_____ Date Drawn:_____ Most recent ALT:_____ Date Drawn:_____
Pre-treatment HBV Viral Load:_____ Date Drawn:_____
Liver biopsy done? ☐ Yes ☐ No Date of liver biopsy:_____ Results of liver biopsy:_____
ANC:_____ /mm³ Date Drawn:_____ Hgb:_____g/dL Date Drawn:_____

Prescription

ORAL THERAPY FOR HEPATITIS B

Drug	Dosage	Directions	Quantity	Refills
☐ Hepsera Adefovir	10mg	PO q Daily	#30	
☐ Baraclude	0.5mg	PO q Daily	#30	
☐ Baraclude Entecavir	1mg	PO q Daily	#30	
☐ Tyzeka Telbivudine	600mg	PO q Daily	#30	
☐ Epivir-HBV Lamivudine	100mg	PO q Daily	#30	
☐ L-carnitine	330mg	3 PO BID	#180	
☐ L-carnitine	330mg	3 PO TID	#270	
☐ Tenofovir	300mg	PO q Daily	#30	

Prescriber Information

Anticipated Start Date:_____ Physician Specialty:_____ Ship to: ☐ Patient ☐ Physician/Clinic
☐ Other:_____
Physician Name (please print):_____ Contact Name:_____
Phone #:_____ Fax #:_____ NPI #:_____
Office Address:_____ City:_____ State:_____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process & to receive patient lab values.

Physician's Signature:_____ Date:_____