

## Patient Information – Please attach a copy of the patient’s insurance card

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			City:		State:
Phone Number:			Alternate Phone Number:		Language:
Allergies (Required):		<input type="checkbox"/> NKDA	Height:	Weight:	SSN:
Product Shipping Options: <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:					

## Prescriber Information

Practice Name:			Office Contact:		
Prescriber:		NPI:		DEA:	
Practice Address:		City:		State:	Zip:
Phone Number:		Fax Number:			
Prescriber Primary Specialty: <input type="checkbox"/> Pain <input type="checkbox"/> Addiction <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Other:					

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

ICD-10/Diagnosis: <input type="checkbox"/> B18.1 (Chronic HBV) <input type="checkbox"/> Other:		Does the patient have cirrhosis? <input type="checkbox"/> No <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated			
Co-Infections: <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis C		Has the patient been HBsAg positive for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the patient HBeAg positive? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient had a persistent serum ALT $\geq$ 2 times above upper limits of normal (ULN)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prior Failed Therapy:					
Has the patient had a liver transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient awaiting a liver transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		HBV DNA Level:	

## Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Baraclude® (entecavir)	<input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 1 mg tablet	Take one tablet by mouth daily without food	30	
<input type="checkbox"/> Vemlidy® (tenofovir alafenamide)	25 mg tablet	Take one tablet by mouth daily with food	30	
<input type="checkbox"/> Epivir-HBV® (lamivudine)	100 mg tablet	Take one tablet by mouth daily	30	
<input type="checkbox"/> Hepsera® (adefovir dipivoxil)	10 mg tablet	Take one tablet by mouth daily	30	
<input type="checkbox"/> Pegasys® (pegylated interferon)	<input type="checkbox"/> 180 mcg/0.5 mL PFS <input type="checkbox"/> 180 mcg/0.5 mL vial <input type="checkbox"/> 180 mcg/0.5 mL ProClick™	Inject 180 mcg sub-Q once weekly for 48 weeks	4 PFS	
<input type="checkbox"/> 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
<input type="checkbox"/> Check here to authorize Curexa™ 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”			