TruCare PHARMACY

Phone: (844) 446-0808 | Fax: (844) 446-0809

HEPATITIS B PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician ☐ Pick-Up (store location)

Patient Name(Required):	DOB (Required):	Physician Name:	
Home Phone:	Cell Phone:	LIC#:	DEA #:
Address/City/State/Zip:		NPI#:	Specialty:
Emergency Contact Name/Phone #:		Address:	
Patient Soc. Sec #:	Allergies: ☐ NKA	City:	State: Zip:
Height:	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of all insurance cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone:	Phone:	Phone:	Group #:

DIAGNOSIS INFORMATION | Please FAX clinical notes, Labs, Tests,with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD-10: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐ **BARACLUDE®**	☐ 0.5mg ☐ 1mg ☐ 0.05mg/ml:	☐ 0.5mg tab by mouth daily ☐ 1mg tab by mouth daily ☐ Other:	30 ml	
☐ **EPIVIR HBV**	☐ 100mg	☐ 100mg by mouth daily	30	
☐ **HEPSERA®**	☐ 10mg	☐ 10mg by mouth daily	30	
☐ **HBIG** (Hepatitis B Immune Globulin-single use vial)				
☐ **PEGASYS®** ☐ Prefilled Syringe ☐ Vial ☐ ProClick®	☐ 90mcg ☐ 135mcg ☐ 180mcg	☐ 90mcg SQ once weekly ☐ 135mcg SQ once weekly ☐ 180mcg SQ once weekly	28 day supply	
TYZEKA®	☐ 600mg	☐ 600mg by mouth daily	30	
VIREAD®	☐ 300mg	☐ 300mg by mouth daily ☐ Other:	30	
ADEFOVIR	☐ 10mg	☐ 10mg by mouth daily	30	
LAMIVUDINE	☐ 150mg ☐ 300mg	☐ 150mg by mouth twice daily ☐ 300mg by mouth daily	☐ 30 ☐ 60	
_ **OTHER**				

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

# of Medications Prescribed: _____

Physician's Signature: _____ ☐ **DAW (Dispense as Written)** **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Please use new form for additional items. tcv110116