

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: _____ /mm3 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 separate 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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