



Hepatitis B Prescription Form

Phone (310) 360.9969 Fax (310) 360.9959
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cienegapharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA#	NPI#	License#
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____ ICD-9: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Baraclude	0.5mg 1mg 0.05mg/ml:	<input type="checkbox"/> 0.5mg tab by mouth daily <input type="checkbox"/> 1mg tab by mouth daily <input type="checkbox"/> Other:	30 <input type="checkbox"/> ml	
<input type="checkbox"/> Epivir HBV	<input type="checkbox"/> 100mg	<input type="checkbox"/> 100mg by mouth daily	30 <input type="checkbox"/>	
<input type="checkbox"/> Hepsera	<input type="checkbox"/> 10mg	<input type="checkbox"/> 10mg by mouth daily	30 <input type="checkbox"/>	
<input type="checkbox"/> HBIG (Hepatitis B Immune Globulin - single use vial)				
<input type="checkbox"/> Pegasys <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial <input type="checkbox"/> ProClick	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 180 mcg SQ once weekly <input type="checkbox"/> 90 mcg SQ once weekly <input type="checkbox"/> 135 mcg SQ once weekly	28 day supply	
<input type="checkbox"/> Tyzeka	<input type="checkbox"/> 600mg	<input type="checkbox"/> 600mg by mouth daily	30	
<input type="checkbox"/> Viread	<input type="checkbox"/> 300mg	<input type="checkbox"/> 300mg by mouth daily <input type="checkbox"/> Other:	30	

By signing this form, Cienega Pharmacy and its staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

Prescriber's Signature (no stamps) Date _____
If Brand required check DAW

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