**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.** Prescribers are reminded patients may choose any pharmacy of their choice.

# Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

# HEPATITIS B ENROLLMENT FORM

**Date Medication Needed:** ________ **Ship To:** Patient's Home Prescriber's Office Pick-up: Injection training by pharmacy?

## 1: Patient Information

**Patient Name:** ________ **Birthdate:** ________ **Sex:** Male Female **Height:** ________ **Weight:** ________ lbs. kg.

**Soc. Sec. #:** ________ **Preferred Phone:** ________ **Known Allergies:** ________

**Address:** ________ **City:** ________ **State:** ________ **Zip:** ________

**Alternate Caregiver Name:** ________ **Preferred Phone:** ________

**Insurance Information:** Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

## 2: Prescriber Information

**Provider Name:** ________ **DEA#:** ________ **NPI#:** ________ **Tax ID#:** ________

**Address:** ________ **Phone:** ________ **Fax:** ________

**City, State, Zip:** ________ **Key Contact:** ________ **Phone:** ________

## 3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

**Diagnosis:** ________ **ICD-10:** ________

## 4: Prescription Information

| Medication | Dose/Strength | Sig | Qty. | Refills |
|---|---|---|---|---|
| **Baraclude®** | 0.5mg<br>1mg<br>0.05mg/ml: | 0.5mg tab by mouth daily<br>1mg tab by mouth daily<br>**Other:** | 30<br>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®**<br>Prefilled Syringe Vial<br>ProClick® | 180mcg<br>135mcg | 180 mcg SQ once weekly 90 mcg SQ once weekly<br>135 mcg SQ once weekly | 28 day supply | |
| **Tyzeka®** | 600mg | 600mg by mouth daily | 30 | |
| **Vemlidy®** | 25mg | 25mg by mouth daily with food | 30 | |
| **Viread®** | 300mg | 300mg by mouth daily<br>**Other:** | 30 | |
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**Patient:** By signing this form, patient agrees to release his/her PHI to Twin Oaks Specialty Pharmacy for the purpose of medical and pharmaceutical treatment as per HIPAA compliance and to enroll in the pharmaceutical company assisted patient support programs. **Patient Signature:** **Date:**

**Prescriber Signature:** By signing this form, and utilizing our services, you are also authorizing Twin Oak Specialty Pharmacy to serve as your designated agent in dealing with medical and prescription insurance companies and co-pay assistance foundations.

Dispense as written Date Substitution Permissable **Date:**

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

*rev 3.20.18*