Kohll's RX SPECIALTY CARE

HEPATITIS B SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Select Diagnosis: ❑ Acute Infection ❑ Chronic Infection Date of Diagnosis: _____ ICD-10: _____

HBsAg (+/-) _____ Date(s) : _____-_____
HBeAb (+/-) _____ Date : _____
HBV DNA (u/mL) _____ Date :_____
ALT_____ Date : _____

Is the patient treament naïve? ❑ Yes ❑ No
Is the patient currently receiving the requested medication? ❑ Yes ❑ No
If no, is the patient receiving another Hepatitis B medication? ❑ Yes ❑ No
If yes, list medication:_____

Does the patient have renal impairment? ❑ Yes ❑ No Creatinine Clearance:_____ Date:_____
Patient has decompensated cirrhosis? ❑ Yes ❑ No
Patient has viral co-infection (e.g. HepC or HIV)? ❑ Yes ❑ No
Patient has compensated cirrhosis? ❑ Yes ❑ No
Has the patient had a liver biopsy done? ❑ Yes ❑ No Results:_____
Is the patient scheduled or has had a liver transplant? ❑ Yes ❑ No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ENTECAVIR	❑ Treatment Naïve: 0.5 mg tablets ❑ Decompensated Liver Disease: 1 mg tablets	❑ For both indications, take 1 tablet by mouth once daily	30	
❑ VIREAD	❑ 300 mg tablets	❑ Take 1 tablet by mouth once daily	30	
❑ VEMLIDY	❑ 25 mg tablets	❑ Take 1 tablet by mouth once daily	30	
❑ OTHER :	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.