PH: 888-588-1072
FAX: 866-388-1488
ParagonSpecialty.com

PARAGON SPECIALTY

HEP B Order Form

PATIENT INFORMATION

☐ *demographics attached*

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____ Patient SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION: *PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK*

MEDICAL INFORMATION

Weight: _____ Height: _____ BSA: _____

Diagnosis: ☐ Hepatitis B ☐ HIV/HBV co-infected ☐ HCV/HBV co-infected ☐ Other: _____

PCR and HPV DNA (Viral Load) _____ copies/ml Date: _____

E-antigen + (HBeAg-) ☐ Yes ☐ No

Has patient been treated previously for this condition? ☐ Yes ☐ No

If yes, please list medication(s): _____

Is patient currently on therapy? ☐ Yes ☐ No

If yes, please list medication(s): _____

PLEASE SEND LAST OFFICE NOTE AND MOST CURRENT LABS WITH REFERRAL TO AID IN PA PROCESS

PRESCRIPTION INFORMATION

☐ **New** ☐ **Refill** **Needs by:** ____/____/_____ **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

DRUG	DIRECTIONS	QUANTITY	REFILLS
☐ Viread® 300mg	☐ 300mg PO daily ☐ Dose adjustment by Creatinine Clearance (if less that 50ml/min)	30 day supply	
☐ Vemlidy® 25mg	☐ Take one 25mg tablet once daily with food.	30 day supply	
☐ Hepsera® 10mg	☐ 10mg PO daily ☐ Dose adjustment by Creatinine Clearance (if less that 50ml/min)	30 day supply	
☐ Baraclude®	☐ 0.5mg tab PO daily (Naïve patient or adolescents 16 or older) ☐ 1 mg tab PO daily (Lamivudine – Refractory patient) ☐ 0.05 mg/ml _____ ☐ Does adjustments by Creatinine Clearance (if less than 50 ml/min)	30 day supply	
☐ Epivir HBV® 100mg	☐ 100mg PO daily	30 day supply	
☐ Epivir 150mg	☐ 150mg PO BID (only for co-infected patient with HIV)	30 day supply	
☐ Tyzeka®	☐ 600mg PO daily ☐ Dose adjustment by Creatinine Clearance (if less that 50ml/min)	30 day supply	
☐ Pegasys® ☐ PFS ☐ ProClick	Inject: ☐ 180mcg ☐ 135mcg ☐ 90mcg subcutaneously weekly	28 day supply	
☐ Epipen			
☐ Other:			

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____ Tax ID: _____

NPI: _____ DEA: _____ License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Person: _____