MOUNTAINVIEW PHARMACY

Where we deliver care...

Fax: 770-272-9613

HEP B

Must Be Filled Out

❑ New Patient ❑ Current	Date
Patient's Name	Date Medication Needed:
D.O.B. ❑ Male ❑ Female Last 4 digits of SSN	Prescriber's Name and Title
Street Address Apt #	Street Address Suite #
City State Zip	City State Zip
Home Phone Cell Phone	Phone Fax
E-mail Address	NPI #
Insurance Bin/PCN/Grp/ID	DEA #
Insured's Name	
Relationship to Patient	
Does Patient have a secondary insurance? ❑ Yes ❑ No	
Allergies	

In order to dispense brand, BRAND MEDICALLY NECESSARY must be handwritten:

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Diagnosis/Clinical Information

Diagnosis:	ICD-10:

Prescription Information

Medication	Dose / Strength	Sig	Qty	Refills
❑ Baraclude®	❑ 0.5mg ❑ 1mg ❑ 0.05mg/ml:	❑ 0.5mg tab by mouth daily ❑ 1mg tab by mouth daily ❑ Other:	30 _________ml	
❑ Epivir HBV	❑ 100mg	❑ 100mg by mouth daily.	30 _________	
❑ Hepsera®	❑ 10mg	❑ 10mg by mouth daily.	30 _________	
❑ HBIG (Hepatitis B Immune Globulin - single use vial				
❑ Viread®	❑ 300mg	❑ 300mg by mouth daily. ❑ Other	30	
❑ Vemlidy®	❑ 25mg	❑ 1 tablet by mouth daily with food	30	
❑ Other				

I authorize Mountainview Pharmacy, Inc and its representative to act as my agent to initiate and execute insurance prior authorization process for this script and any future fills of the same script for the patient listed above and to sign any forms necessary on my behalf as an authorized agent. I understand I can revoke this designation at any time.

Physician Office Contact: Name:	Email:

Physician Signature:	Date:

Email: mountainview2327@att.net