BURBANK SPECIALTY PHARMACY

Phone: 818-563-2120
Fax: 844-500-3843

Hepatitis B Form

Patient Name:	Today's Date:
DOB SSN	Prescriber:
Home Phone Work/Other Phone	Phone Number Fax Number
Home Address	Address
Shipping Address (If different from home address)	Office Contact: Prefers: □ Fax □ Phone □ E-mail _____
Language Preference: □ English □ Spanish □ Other _____	Ship to: □ Home □ MDO NEED CLASS_____

Rx:

TAPE PRESCRIPTION HERE PRIOR TO FAXING **OR** COMPLETE THE FOLLOWING:

□ **Lamivudine 100mg**
One 100 mg tablet once daily
Qty: _____ **Refill x** _____

□ **Telbivudine 600mg**
One 100 mg tablet once daily
Qty: _____ **Refill x** _____

□ **Entecavir 0.5 mg (Under 30kg)**
One 0.5mg tablet once daily
Qty: _____ **Refill x** _____

□ **Entecavir 1.0mg (Above 30kg)**
Two 0.5mg tablets once daily

□ **Adefovir 10mg**
One 10mg tablet once daily
Qty: _____ **Refill x** _____

□ **Tenofovir 300mg**
One 300mg tablet once daily
Qty: _____ **Refill x** _____

Physician Signature: _____ **DEA:** _____