

**Patient Information - Please send demographic sheet and a copy of the patient's insurance cards**

Patient Name:	Date of Birth:	Male	Female
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:	Language:	
Allergies (Required):	NKDA	Height:	Weight:
Medication Delivery Options:	Patient's Home	Hospital/Clinic Office	Bedside
<b>Delivery Address:</b>			

**Prescriber Information**

Practice Name:	Office Contact:
Prescriber:	NPI:
Practice Address:	City:
Phone Number:	Fax Number:

**Clinical Information - Please send all available chart notes including lab results**

ICD-10:	CrCl (ml/min):
Therapies tried and failed with length of treatments:	

Medication	Strength	Dose/Frequency
Entecavir	<b>SELECT PRODUCT(s):</b>  <b>Tablets:</b> 0.5 mg 1 mg <b>Oral Solution:</b> 0.05 mg/mL	<b>Compensated Liver Disease for adults and adolescents (over 16 years of age):</b> Take 0.5 mg by mouth once daily Take 1 mg by mouth once daily <b>Decompensated Liver Disease:</b> Take 1 mg by mouth once daily <b>Renal Impairment:</b> CrCl (mL/min) ≥50: Take 0.5 mg by mouth once daily CrCl (mL/min) 30 to <50: Take 0.25 mg by mouth once daily or 0.5 mg every 48 hours CrCl (mL/min) 10 to <30: Take 0.15 mg by mouth once daily or 0.5 mg every 72 hours CrCl (mL/min) <10 or Hemodialysis or CAPD: Take 0.05 mg by mouth once daily 0.5 mg every 7 days <b>Lamivudine-Refractory Decompensated Liver Disease:</b> CrCl (mL/min) ≥50: Take 1 mg by mouth once daily CrCl (mL/min) 30 to <50: Take 0.5 mg by mouth once daily or 1 mg every 48 hours CrCl (mL/min) 10 to <30: Take 0.3 mg by mouth once daily or 1 mg every 72 hours CrCl (mL/min) <10 or Hemodialysis or CAPD: Take 0.1mg by mouth once daily or 1 mg every 7 days
Lamivudine	<b>SELECT PRODUCT(s):</b>  100 mg Tablets 5mg/mL Oral Solution	<b>Pediatric Patients:</b> Take 3 mg/kg by mouth once daily , MDD of 100 mg <b>Adult Patients:</b> Take 100 mg by mouth once daily <b>Adult Patients with Renal Impairment:</b> CrCl (mL/min) ≥50: Take 100 mg by mouth once daily CrCl (mL/min) 30 to 49: Take 100 mg by mouth as first dose, then 50 mg by mouth once daily CrCl (mL/min) 15 to 29: Take 100 mg by mouth as first dose, then 25 mg by mouth once daily CrCl (mL/min) 5 to 14: Take 35 mg by mouth as first dose, then 15 mg by mouth once daily CrCl (mL/min) <5: Take 35 mg by mouth as first dose, then 10 mg by mouth once daily
Adefovir dipivoxil	<b>SELECT PRODUCT(s):</b>  10 mg Tablets	<b>Chronic Hepatitis Patients (12 years of age and older):</b> 10 mg by mouth once daily <b>Adult Patients with Renal Impairment:</b> CrCl (mL/min) ≥50: Take 10 mg by mouth every 24 hours CrCl (mL/min) 30 to 49: Take 10 mg by mouth every 48 hours CrCl (mL/min) 10 to 29: Take 10 mg by mouth every 72 hours <b>Hemodialysis Patients:</b> Take 10 mg every 7 days following dialysis
Tenofovir disoproxil Tenofovir alafenamide	<b>SELECT PRODUCT(s):</b>  <b>Tablets:</b> 25 mg 300 mg	<b>Chronic Hepatitis patients (12 years of age and older):</b> 300 mg tablet Powder formulation (7.5 scoops) by mouth once daily. <b>Adult Patients with Renal Impairment:</b> CrCl (mL/min) 10 to 29: Take 300 mg by mouth every 72-96 hours CrCl (mL/min) 30 to 49: Take 300 mg by mouth every 48 hours

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

**IMPORTANT NOTICE:** This form is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.

**\*Fax does not constitute a valid prescription as per NYS Board of Pharmacy. Please electronically prescribe order.**

**Prescriber Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_