CoxHealth at Home

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

Hepatitis B

patient information

patient: _____ male / female DOB: _____ SS#: _____
(last name, first name)

address: _____
(street, city, state, zip)

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs / kg date: _____

clinical information

Current medications (if necessary, please fax copy of complete list): _____

Diagnosis/ICD-10: other: _____

Previously treated with interferon? (Y / N)

Start date of hep B therapy: _____

Pre-treatment ALT: _____ date: _____

Most recent ALT: _____ date: _____

Pre-treatment HBV viral load: _____ date: _____

ANC: _____ /mm^3 date: _____

Liver biopsy: (Y / N) results: _____ date: _____

Hgb: _____ g/dL date: _____

To order an Hepatitis B medication, please either fill out the prescription below OR fax a seperate prescription with this referral form

Drug/Dose/Route/Frequency: _____

_____

_____

Quantity to Dispense: _____

Refills: _____

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate _____
(shipping address: street, city, state, zip)

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)