

Request Form for Chronic Hepatitis B Agents

(pegylated interferon alfa-2a [Pegasys®], adefovir [Hepsera®], entecavir [Baraclude®], telbivudine [Tyzeka®])

Physician Information

Name: _____
 # License: _____
 Physician specialty: _____
 Address: _____

 Telephone: _____ Fax: _____

Patient Information

Name: _____
 Date of birth: _____ Sex: M F
 Member ID: _____
 Address: _____

Medication(s) requested

- | | |
|---|--|
| <input type="checkbox"/> adefovir [Hepsera®]

<input type="checkbox"/> entecavir [Baraclude®] | <input type="checkbox"/> pegylated interferon alfa-2a [Pegasys®]

<input type="checkbox"/> telbivudine [Tyzeka®] |
|---|--|

Diagnosis

Which diagnosis does the patient have?

Chronic Hepatitis B

Other, specify _____

Medical Information

Please provide the following information

1. HBs Ag (> 6 months): Yes No
2. HBe Ag: Positive Negative
3. HBV DNA (by PCR) : _____ IU/mL or _____ copies/ mL
4. ALT levels: _____ U/I
5. Cirrhosis: Yes No , if yes please specify current status : compensated or decompensated

Abbreviations: ALT - alanine aminotransferase; ULN - upper limit of normal

* ALT UNL: 30 U/I men; 19 U/I women

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date: _____