

HEPCLUDEX INJECTION ORDER

(bulevirtide-gmod)

1 PATIENT INFORMATION

Patient Name: _____
 Primary Phone: _____ DOB: _____
 Address: _____
 City, State, Zip: _____
 Allergy: _____
 Gender: Male Female
 ICD-10 Code: B18.0 Other _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI#: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____
 HCP Office Email: _____

3 PRESCRIPTION INFORMATION

MEDICATION

HEPCLUDEX: supplied as a single-dose vial of lyophilized powder for subcutaneous injection after reconstitution (after reconstitution with 1mL of Sterile Water for Injection, each vial delivers 8.5mg of bulevirtide-gmod)

ROUTE	DIRECTIONS	QUANTITY	REFILLS
<input checked="" type="checkbox"/> Subcutaneous (SC)	<input checked="" type="checkbox"/> Inject 8.5mg HEPCLUDEX subcutaneously once daily	30 Day Supply	_____
Supplies	<input checked="" type="checkbox"/> I authorize ancillary supplies such as alcohol wipes, sterile syringes, sterile transfer needles, sterile injection needles, cotton balls and/or gauze, adhesive bandages, a sharps container and Sterile Water for Injection as needed to prepare and administer the therapy.		

4 PROVIDER SIGNATURE

X

 PRODUCT SUBSTITUTION PERMITTED SIGNATURE Date of Signature

X

 DISPENSE AS WRITTEN SIGNATURE Date of Signature

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.