

Date of Request _____

Tyzeke Tyzeke (telbivudine) is for treatment of adult patients with chronic hepatitis B with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.

Member Information

Relationship (Circle)

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth date _____
 Address: _____
 City State Zip _____

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____ Weight (kg): _____

Practitioner Information

Name _____
 Agent / Contact Name _____
 Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - _____
 Fax () - _____
 ID Number _____
 Email _____ @ _____

ALT or AST _____

Requested Drug / Pharmaceutical

Tyzeke (telbivudine)

Strength / Dose

Therapy Start Date

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Condition / Diagnosis Related - Reason for Request

Clinical Drug / Lab History Pertinent to Request

<u>Labs:</u>	<u>Baseline / Ongoing</u>
<p>Formulary Alternative(s) Attempted YES NO (Circle) Please List:</p>	

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature