

## Hep B Drug Coverage Verification Form

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Hepatologist: \_\_\_\_\_

Transplant Coordinator: \_\_\_\_\_

Hep B Coverage adequate:

Yes       No (If no, please provide comments)

Comments:

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**Viread** (Tenofovir disoproxil) 300 mg daily

**Baraclude** (Entecavir) 0.5 mg daily

**Vemlidy** (Tenofovir alafenamide) 25 mg daily

Co-pay \$ \_\_\_\_\_

Co-pay \$ \_\_\_\_\_

Co-pay \$ \_\_\_\_\_

Consent:

Yes       No (If no, please provide comments)

Comments:

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