**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

# AccuPac™ Signup Sheet

**Pharmacy 800-727-5823**

**FAX 412-586-5351**

Start Date

Ship To: ☐ Patient ☐ Office ☐ **Other**

**1. Patient Information:** **Please fax front and back copy of the insurance card (Prescription and Medical)**

Patient: ______________________ ______________________ Male / Female DOB: ____________ Soc. Sec. #______________
First Name Last Name

Address: ____________________________________________________________________
Street City State Zip

Primary phone number: ______________________ Alternate phone number: ______________________

Caregiver: ______________________ Allergies: ______________________

Comorbidities: ______________________ Height: __________ Weight: __________

**2. Prescription Information:**

Prescription #1

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #2

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #3

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #4

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #5

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #6

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

Prescription #7

| Medication | Dosage | Quantity | Directions | Refills | Time to Take |
|---|---|---|---|---|---|
| | | | | | |

**3. Prescriber and Shipping Information:**

**Prescriber (print):**______________________ **Office Contact:** ______________________

**Preferred method of contact:** ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**______________________

**Office Address:** ______________________

**Phone:** ______________ **fax:**______________ **NPI:**______________ **DEA:**______________

**Prescriber's Signature:** ______________________ **Date:**______________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process**. (NO STAMPS)**

**4. Patient Support Programs (optional):** **Please sign below to enroll in the pharmaceutical company assisted patient support program**

**Patient Signature:** ______________________ **Date:**______________

**5. Insurance Information:** **Please fax a copy of the insurance card (front & back)**

***IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 412-586-5351.. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.**