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

AccuSERV PHARMACY

HEPATITIS C REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

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. Clinical Information: Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis: _____ **ICD-10**_____**Genotype:**_____**Subtype:**_____ **Viral Load:**_____

NS Q80K Polymorphism Results:_____**Prior Treatment and Date:**_____

Response Status: ☐ **Naïve** ☐ **Null** ☐ **Partial** ☐ **Relapse** **Compensated Cirrhosis: (YES / NO)** **Fibrosis Score:**_____

3. Prescription Information: If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
☐ **Daklinza®** (daclatasvir)	☐ 60mg/tablet ☐ 30mg/tablet	Take 1 tablet by mouth daily with or without food Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other_____	28 days	
☐ **Harvoni®** (Ledipasvir/sofosbuvir)	☐ 90mg/400mg tablet	Take 1 tablet by mouth daily with or without food Anticipated treatment duration ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	28 days	
☐ **Olysio-**	☐ 150mg/capsule	Take 1 tablet by mouth once daily with food Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other_____	28 days	
☐ **Pegasys®** ☐ Prefilled Syringe ☐ Vial ☐ ProClick®	☐ 180mcg ☐ 135mcg	☐ 180mcg SQ once weekly ☐ 90mcg SQ once weekly ☐ 135mcg SQ once weekly	28 days	
☐ **Peg-Intron®**	☐ 50mcg/0.5 mi ☐ 80mcg/0.5 mi ☐ 120mcg/0.5 mi ☐ 150mcg/0.5mi	☐ 50mcg (0.5ml)SQ once weekly ☐ 64mcg (0.4ml)SQ once weekly ☐ 80mcg (0.5ml)SQ once weekly ☐ 96mcg (0.4ml)SQ once weekly ☐ 120mcg (0.5ml)SQ once weekly ☐ 150mcg (0.5ml)SQ once weekly	28 days	
☐ **RibaSphere®** (generic ribavirin)	☐ 200mg			
☐ **RibaPak®** ☐ **Moderiba®**	☐ 600mg/day ☐ 800mg/day ☐ 1000mg/day ☐ 1200mg/day	☐ 200mg tablet QAM , 400mg tablet QPM (56 tabs) ☐ 400mg tablet QAM , 400mg tablet QPM (56tabs) ☐ 600mg tablet QAM, 400mg tablet QPM (56tabs) ☐ 600mg tablet QAM, 600mg tablet QPM (56 tabs)	28 days	
☐ **Sovaldi™**	☐ 400mg tablet	Take 1 tablet by mouth daily with or without food Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other_____	28 days	
☐ **Technivie™** (ombitasvir, paritaprevir, and ritonavir tablets)	☐ 12.5mg/75mg/50mg	Take 2 tablets in the AM with food. Quantity: 56 Anticipated treatment duration: ☐ 12 weeks ☐ Other _____	28 days	
☐ **Viekira Pak™** (ompitasvir, paritaprevir, and ritonavir tablets copackaged with dasabuvir tablets)	☐ 12.5mg/75mg/50mg/250mg	Take 3 tablets in the AM and 1 tablet in the PM with food. Quantity: 112 Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other_____	28 days	
☐ **Zepatier™**	☐ 50mg/100mg	Take tablet daily by mouth. Anticipated treatment duration; ☐ 12 weeks ☐ 16 weeks	28 days	

4. 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)

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

Patient Signature:_____**Date:**_____

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