**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

Start Date

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

FAX: 877-526-8823

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)	☐ 60 mg/tablet ☐ 30 mg/tablet	Take 1 tablet by mouth daily with or without food Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other _____	28 days	
☐ Epclusa® (velpatasvir/sofosbuvir)	☐ 100 mg/ 400 mg tablet	Take 1 tablet by mouth daily Anticipated treatment duration: ☐ 12 weeks	28 days	
☐ Harvoni® (Ledipasvir/sofosbuvir)	☐ 90 mg/ 400 mg tablet	Take 1 tablet by mouth daily with or without food Anticipated treatment duration: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	28 days	
☐ Olysio™	☐ 150 mg/capsult	Take 1 tablet by mouth once daily with food Anticipated treatment duration: ☐ 12 weeks ☐ 24 weeks ☐ Other _____	28 days	
☐ **Pegasys®** ☐ Prefilled Syringe ☐ Vial ☐ ProClick®	☐ 180 mcg ☐ 135 mcg	☐ 90 mcg SQ once weekly ☐ 135 mcg SQ once weekly ☐ 180 mcg SQ once weekly	28 days	
☐ Peg-Intron®	☐ 50 mcg/0.5 ml ☐ 80 mcg/0.5 ml ☐ 120 mcg/0.5 ml ☐ 150 mcg/0.5 ml	☐ 50 mcg (0.5ml) SQ once weekly ☐ 64 mcg (0.4ml) SQ once weekly ☐ 80 mcg (0.5ml) SQ once weekly ☐ 96 mcg (0.4ml) SQ once weekly ☐ 120 mcg (0.5ml) SQ once weekly ☐ 150 mcg (0.5ml) SQ once weekly	28 days	
☐ RibaSphere® (generic ribavirin)	☐ 200 mg			
☐ RibaPak® ☐ Moderiba®	☐ 600 mg/day ☐ 800 mg/day ☐ 1000 mg/day ☐ 1200 mg/day	☐ 200 mg tablet QAM, 400 mg tablet QPM (56 tabs) ☐ 400 mg tablet QAM, 400 tablet QPM (56 tabs) ☐ 600 mg tablet QAM, 400 mg tablet QPM (56 tabs) ☐ 600 mg tablet QAM, 600 mg tablet QPM (56 tabs)	28 days	
☐ Solvadi™	☐ 400 mg 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)	☐ 12.5 mg/75 mg/50 mg	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 copacked with dasabuvir tablets)	☐ 12.5 mg/75 mg/50 mg/250 mg	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™	☐ 50 mg/100 mg	Take 1 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 authorizeAccuServ 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)

 Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.