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

AccuSERV® PHARMACY

Hepatitis B Enrollment Form

Fax: (877) 526-8823

Clear Form

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

Start Date:_____ Ship to : ☐ Patient ☐ Office _____ Other

1. Patient Information

Patient Name:_____ ○Male ○Female DOB:_____

Address: _____ SSN:_____

Caregiver:_____ Allergies: _____Weight: _____

Phone #:_____ Alt Phone #:_____Comorbidities:_____

2. Clinical Information *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:_____ Pre-Treat.HBV viral load:_____ Date: _____

Liver Biopsy ○yes ○no Result:_____ ANC:_____ Date: _____Hgb: _____ Date: _____

Pre-Treat. ALT:_____ Date:_____ Most Recent ALT: _____Date:_____

Prior Therapy: _____ Reason for Discontinuation: _____

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions *(be specific)*	Quantity	Refills
☐	Baraclude®	○ 0.5mg ○1mg	☐ take _____ mg by mouth _____ times a day	_____ tablets	
		○ 0.05mg/mL oral solution	☐ take _____mL by mouth _____ times a day	_____ mL	
☐	Epivir HBV®	○ 100mg	☐ take _____ mg by mouth _____ times a day	_____ tablets	
		○ 5mg/mL oral solution	☐ take _____mL by mouth _____ times a day	_____ mL	
☐	Hepsera®	○ 10mg	☐ take _____ mg by mouth _____ times a day	_____ tablets	
☐	Vemlidy®	○ 25mg	☐ take _____ mg by mouth _____ times a day	_____ tablets	
☐	Viread®	○150mg ○200mg ○250mg ○300mg	☐ take _____mg by mouth _____ times a day	_____ tablets	
		○ 40mg/scoop oral powder	☐ mix _____ scoop(s) w/_____oz soft food & eat STAT	____ 60g box(s)	
☐	Pegasys®	○ 180mcg/0.5mL	☐ inject 180mcg Sub-Q in thigh/abdomen _____times/week	_____ PFS _____ Proclick®	
		○ 180mcg/1mL	☐ inject 180mcg Sub-Q in thigh/abdomen _____times/week	____ (1mL) vials	
☐					
☐					

4. Prescriber and Shipping Information

Prescriber (print) : _____ Office Contact: _____

Pref. Method of Contact: ○ phone ○ fax ○ email Contact 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. Insurance Information *Please fax a copy of insurance card front and back. Enlarge if possible.*

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