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

Clear Form

AccuSERV® PHARMACY

Heart Transplant Prescription Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821

Single Point of Contact: (724) 515-7053

1. Patient Information

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

Patient Name: _____ ○M ○F DOB:_____ Soc.Sec #_____

Address: _____ Phone #: _____

Caregiver:_____ Allergies: _____ Alt Phone #:_____

2. Clinical Information

Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization

ICD -10/ Diagnosis Code:_____ Date of Transplant: _____ Organ:_____

Special Instructions: _____ Medicare Part A:○yes○no Medicare Part B:○yes○no

3. Prescription Information

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

Astagraf XL®	**Strength:**		**Crestor®**	**Strength:**		**Prednisone**	**Strength:**		**Zocor®**	**Strength:**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**
Baby Aspirin EC	**81 mg**		**Lasix®**	**Strength:**		**Prilosec®**	**Strength:**		**Zovirax®**	**400 mg**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**
Bactrim®	**800/160 mg(DS)**		**Lipitor®**	**Strength:**		**Prograf®**	**Strength:**			**Strength:**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**
Cardizem CD	**Strength:**		**Magnesium Oxide**	**400 mg**		**Rapamune®**	**1mg**			**Strength:**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**
Cellcept®	☐**250mg cap** ☐**500 mg tab**		**Nexium®**	**40 mg**		**Revatio®**	**20 mg**			**Strength:**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**
Colace®	**100 mg**		**Oscal®**	**500 mg**		**Valcyte®**	**450 mg**			**Strength:**	
Sig:	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**	**Sig:**	**QTY**	**Refills**

Please fax list of patient's other medications & choose packaging: ☐ **AccuPAC®** ☐ **Bottles** ☐ *Check here to learn more about AccuPAC®*

☐ **Check here for medications to be dispensed as BRAND, otherwise generics will be substituted when available**

4. Prescriber and Shipping Information

Prescriber (print) : _____ Office Contact: _____

Pref. Method of Contact: ☐ phone ☐ fax ☐ email Contact email: _____

Office Address: _____

Phone: _____ Fax: _____ NPI: _____

Prescriber's Signature:_____ Date: _____DEA:_____

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.

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 (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.

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