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

AccuSERV® PHARMACY

Hepatitis C 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:_____ Viral load:_____ Date:_____ Fibrosis Score:_____

Genotype: _____ Subtype: _____ Compensated Cirrhosis ○yes ○no Prior Therapy: _____

NS Q80K Polymorphism Results: _____ Response Status: ○Naïve ○Null ○Partial ○Relapse

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
	Daklinza®	○ 30 mg ○ 60 mg	○ Take 1 tablet by mouth daily	☐ 28 tablets	
	Epclusa®	○ 100/400 mg	○ Take 1 tablet by mouth daily	☐ 28 tablets	
	Harvoni®	○ 90/400 mg	○ Take 1 tablet by mouth daily	☐ 28 tablets	
	Mavyret®	○ 100/400 mg	○ Take 3 tablets by mouth daily	☐ 84 tablets	
	Olysio®	○ 150 mg	○ Take 1 capsule by mouth daily, with food	☐ 28 capsules	
	Pegasys®	○ 180mcg/ 0.5mL	○ Inject 180mcg Sub-Q in thigh or abdomen _____ times a week	_____ PFS _____ Proclick®	
		○ 180mcg/ 1mL	○ Inject 180mcg Sub-Q in thigh or abdomen _____ times a week	_____ 1mL Vials	
	RibaPak®	○ 800 mg / day Pak ○ 1000 mg / day Pak ○ 1200 mg / day Pak	○ Take _____ mg every morning & take _____mg every evening	☐ 56 tablets	
	Ribavirin®	○ 200 mg cap ○ 200 mg tab	○ Take_____ mg in the morning & take_____ mg in the evening	_____capsules _____ tablets	
	Sovaldi®	○ 400 mg	○ Take 1 tablet by mouth daily	☐ 28 tablets	
	Technivie®	○ 12.5/75/50 mg	○ Take 2 tablets in the morning with food	☐ 56 tablets	
	Viekira PAK®	○ 12.5/75/50/250 mg	○ Take 2 tablets by mouth in the morning ○ Take 1 tablet by mouth in the morning & 1 tablet in the evening	☐ 56 tablets	
	Viekira XR®	○ 8.33/50/33.33/200 mg	○ Take 3 tablets by mouth daily	☐ 84 tablets	
	Vosevi®	○ 400/100/100 mg	○ Take 1 tablet by mouth daily with food	☐ 28 tablets	
	Zepatier®	○ 50/100 mg	○ Take 1 tablet by mouth daily	☐ 28 tablets	

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.*

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