ACS Advanced Care Scripts

HepC Referral Form

Phone: 877-985-MEDS (6337)   Fax: 866-679-7131

First Name:	*Middle Initial:*	*Last Name:*	
Date of Birth:	*Gender:* ☐ M ☐ F	*SSN:*	
Street Address:	City:	State:	Zip Code:
Home Phone:	*Work Phone:*	*Cell Phone:*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card

Insurance Carrier Name – Primary:	*Name of Insured:*	*Relationship:*
ID#:	*Group #:*	*Insurance Phone:*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Daklinza	☐30mg ☐60mg ____mg once daily *Use in combination with Sovaldi (Sofosbuvir)		
Epclusa	☐ 1 tablet (400mg Sofosbuvir & 100mg Velpatasvir) by mouth once daily for _____ weeks (standard is 12 weeks)		
Harvoni	☐ 1 tablet (90 Mg Ledipasvir & 400mg Sofosbuvir) PO daily		
Mavyret	☐ 3 tablets PO once daily with food OR ☐ Other:______________________		
Olysio	☐ 150mg PO daily		
Ribavirin tablets	☐ 200mg PO am & 400mg PO pm | ☐ 400mg PO am & 400mg PO pm ☐ 600mg PO am & 400 mg PO pm | ☐ 600mg PO am &600 mg PO pm | Other:___		
Sovaldi	☐ 400mg po daily		
Technivie	☐ 2 tablets (12.5mg Ombitasvir, 75mg Paritaprevir, 50mg Ritonavir) po once daily in the morning		
Viekira	☐ Viekira Pak Ombitasvir 12.5 mg - 2 tablets daily PO in am, Paritaprevir 75mg -2 tablets daily PO in am , Ritonavir 50mg - 2 tablets daily PO in am, Dasabuvir 250 mg PO BID ☐ Viekira XR extended release tablet - 3 tablets PO once daily		
Vosevi	☐ 1 tablet PO once daily		
Zepatier	☐ 1 tablet PO once daily		
Other	☐ Drug:__________________ Strength:_________ Directions:______________________________		

Primary Diagnosis: ____ *ICD-10:*____ *Genotype:* ____ *Viral load* ____

Weight: pounds *Height:* | *Allergies:* ____

Failed Therapies: ____ ***Please provide current medications list:*** ____

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name:		*MD Last Name:*	*DEA #:*
UPIN:	*State License #:*	*NPI:*	*Office Contact Name:*
Office Address:		City:	State: / Zip Code:
Office Phone:		*Office Fax:*	*Office E-mail:*

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐I authorize Advanced Care Scripts to initiate Prior Authorization on my behalf. TLC 08/8/17

Dr.: ***Substitution Permitted***	**Dr.:** ***NO Substitution Permitted***	**Date:**