

Pharmacy Location:	
Pharmacy Phone:	
Pharmacy Fax:	
Date Submitted:	
Submitted by:	

PATIENT INFORMATION Name: Preferred Name: Pronouns DOB: Address: City: Phone: Phone: Email: Sex: Gender Identity: Insurance Information* PATIENT INFORMATION PRESCRIBER INFORMATION Name: Facility: Address: City: Phone: Fax: Phone: Fax: DEA: Office Contact Name: Office Contact Phone: Office Contact Phone: Office Contact Email: Clinical Information Allergies: Diagnosis //CD-10: Genotype:		AcadianaCares		Pharmacy Fax:				
Ship to: PATIENT INFORMATION Name: Preferred Name: Pronouns Address: City: State: Zip: Phone: Alt Phone: Cimal: Sex: Gender Identity: Insurance Information* Plan Name: BiN: PON: Group Number: ID Number: *A copy of front and back of insurance card may be submitted to the pharmacy compliant to state specific prescription form, fax language, etc. Non-compliance with state specific prescription form, fax language, etc. Non-compliance with state specific prescription smay be accepted in form, fax language, etc. Non-compliance with state specific requirements may result in an outreach to the prescriber. Pascriptions will not be accepted if			orm	Date Submitted:				
PATIENT INFORMATION Name: Preferred Name: Pronouns DOB: Address: City: State: Zip: Phone: Alt Phone: Email: Sex: Office Contact Name: Office Contact Name: Office Contact Phone: Office Contact Phone: Office Contact Email: Office Contact Email: Office Contact Email: DINSURANCE Information* PLAIN NAME: BIN: PON: Group Number: BIN: PCN: Group Number: BIN: PCN: Group Number: BIN: PCN: Group Number: Fax: Diagnosis //CD-10: Genotype: Responder Status: Viral Load: Fibrosis Stage: Other Liver Conditions: Previous Therapy: Date: PRESCRIPTION INFORMATION Prescriptions should be submitted to the pharmacy compiliant to state specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compiliance with state specific requirements may result in an outreach to the prescriber. Faxed prescriptions will not be accepted if		Hepatitis C		Submitted by:				
Name: Preferred Name: Pronouns DOB:	Ship to:				Date Needed:			
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Prior-Authorizations	, i		Prior-Autho	orizations				
To facilitate the prior-authorization process, please attach the following documents where appropriate and indicate which documents are attached.	To facilitate the pr	rior-authorization process, please attac			e and indicate whic	h documents	are attached.	
Failed therapies Recent office notes Recent lab work	ρ.							
Prescriber's Signature Date	Prescriber's Sig	nature		_	Date			
The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical	J		he best of my knowledge,	with supporting do		patient's med	dical	
record. By signing above, I authorize AcadianaCares Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization	record. By signing	g above, I authorize AcadianaCares Pha	rmacy and/or its affiliate	pharmacies to com	nplete and submit p	rior authoriza	tion	
requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the prior authorization request as my signature.	requests to payer	s for the prescribed medication for this p	patient and to attach this	Enrollment Form to	the prior authorizat	ion request as	s my	

signature.