AcadianaCares

Pharmacy Enrollment Form

Hepatitis C

Pharmacy Location: _____

Pharmacy Phone: _____

Pharmacy Fax: _____

Date Submitted: _____

Submitted by: _____

Ship to:			Date Needed:_____

PATIENT INFORMATION

Name:		
Preferred Name:		
Pronouns	DOB:	
Address:		
City:	State:	Zip:
Phone:	Alt Phone:	
Email:		
Sex:		
Gender Identity:		

PRESCRIBER INFORMATION

Name:		
Facility:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
DEA:	NPI:	
Office Contact Name:		
Office Contact Phone:		
Office Contact Email:		

Insurance Information*

Plan Name:	
BIN:	
PCN:	
Group Number:	
ID Number:	
*A copy of front and back of insurance card may be submitted with this form.	

Clinical Information

Allergies:	
Diagnosis /ICD-10:	other_____
Genotype:	
Responder Status:	
Viral Load:	Load date:
Fibrosis Stage:	
Other Liver Conditions:	
Previous Therapy:	Date:

PRESCRIPTION INFORMATION

Prescriptions should be submitted to the pharmacy compliant to state specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state specific requirements may result in an outreach to the prescriber. Faxed prescriptions may be accepted only if faxed directly by the prescriber or the prescriber's agent. Prescriptions will not be accepted if faxed by the patient.

Prior-Authorizations

To facilitate the prior-authorization process, please attach the following documents where appropriate and indicate which documents are attached.

☐ Failed therapies ☐ Recent office notes ☐ Recent lab work

Prescriber's Signature_____ Date_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I authorize AcadianaCares Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the prior authorization request as my signature.

signature.

Reset Form