



FAX 1-844-504-3278
 PHONE 1-877-327-8881
 www.FASTACCESSRX.com

HEPATOLOGY FORM

PATIENT INFORMATION:

Patient Name: _____
 Date of Birth: _____ Male: Female:
 Address: _____
 City/State/Zip: _____
 Tel: _____ Alt Tel: _____
 SS#: _____ Wt: _____ Ht: _____
 NKDA: Allergy: _____

INSURANCE INFORMATION:

Primary Pharmacy Insurance _____
 Member Name: _____
 Member ID: _____
 Rx Group #: _____
 BIN# _____ PCN# _____
 Customer Service #: _____

Please attach a copy of the front and back of the patient's insurance card, if available.*****

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis: B18.2 Chronic Hep C C22.0 Hepatocellular Carcinoma Other: _____
 Genotype: 1 1a 1b 2 2a 2b 3 3a 3b 4 4a 4b Other: _____ Viral Load: _____
 Previous Treatment: _____ Non-Responder Responder/Relapser HIV Co-Infection Yes No
 Other medications patient is currently taking (including OTC): _____

PRESCRIBER INFORMATION:

Prescriber Name: _____ Specialty: _____ Date: _____
 Address: _____ City/State/Zip: _____
 Contact Name: _____ Phone #: _____ Fax #: _____
 NPI#: _____ DEA #: _____ UPIN #: _____

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature Below: *(Physician attests this is his/her legal signature. NO STAMPS)*

Substitution Allowed

Dispense as Written

PRESCRIPTION:

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|--|---|--|----------|---------|
| Baraclude® | <input type="checkbox"/> 1mg or <input type="checkbox"/> 5mg | <input type="checkbox"/> Take 1 tablet daily | 30 days | _____ |
| Daklinza® | <input type="checkbox"/> 60mg or <input type="checkbox"/> 30mg | <input type="checkbox"/> Take 1 tablet daily | 28 days | _____ |
| Epclusa® | <input type="checkbox"/> 400mg/100mg | <input type="checkbox"/> Take 1 tablet daily with or without food | 28 days | _____ |
| Epivir-HBV® | <input type="checkbox"/> 100mg | <input type="checkbox"/> Take 1 tablet daily | 30 days | _____ |
| Harvoni® | <input type="checkbox"/> 90-400mg tablets | <input type="checkbox"/> Take 1 tablet daily with or without food | 28 days | _____ |
| Hepsera® | <input type="checkbox"/> 10mg | <input type="checkbox"/> Take 1 tablet daily | 30 days | _____ |
| Olysio® | <input type="checkbox"/> 150mg cap | <input type="checkbox"/> Take 1 capsule by mouth once daily with food | 28 days | _____ |
| <input type="checkbox"/> Ribapak® <input type="checkbox"/> Moderiba Pak® | <input type="checkbox"/> Less than 66 kgs (145lbs) <input type="checkbox"/> 66-80 kgs (145-176lbs) <input type="checkbox"/> 81-105 kgs (178-231lbs) <input type="checkbox"/> Greater than 105 kgs (231lbs) | <input type="checkbox"/> Take 400mg QAM and 400mg QPM <input type="checkbox"/> Take 600mg QAM and 400mg QPM <input type="checkbox"/> Take 600mg QAM and 600mg QPM <input type="checkbox"/> Take 600mg Qam and 600mg QPM with 200mg Ribasphere | 28 days | _____ |
| Ribasphere® | <input type="checkbox"/> 200mg tab <input type="checkbox"/> 200mg cap | | 28 days | _____ |
| Solvaldi® | <input type="checkbox"/> 400mg | <input type="checkbox"/> Take 1 tablet by mouth daily | 28 days | _____ |
| Technivie® | <input type="checkbox"/> 12.5/75/50mg | <input type="checkbox"/> Take 2 tablets by mouth daily with food | 28 days | _____ |
| Victrelis® | <input type="checkbox"/> 200mg | <input type="checkbox"/> Take 4 tablets three times daily with food | 28 days | _____ |
| Viekera® | <input type="checkbox"/> 28 Day Pack | <input type="checkbox"/> Take 2 (ombitasvir, paritaprevir, ritonavir 12.5/75/50mg) tablets every morning and take 1 (dasabuvir 250mg) tablet every morning and evening with a meal | 28 days | _____ |
| Zepatier® | <input type="checkbox"/> 50mg/100mg | <input type="checkbox"/> Take 1 tablet daily with or without food | 28 days | _____ |
| Other | _____ | _____ | _____ | _____ |