

Request for supply of Sovaldi®▼ (sofosbuvir) or Harvoni®▼ (ledipasvir and sofosbuvir) or Cayston®▼ (aztreonam lysine) or Epclusa®▼ (sofosbuvir/velpatasvir) for the purpose of dispensing by Community Pharmacy to NHS Scotland patients

Faxback on 01604 433595 or e-mail to alcuraorders@alcura-health.co.uk

To Alcura UK Ltd

Please supply Sovaldi (sofosbuvir) / Harvoni (ledipasvir and sofosbuvir) tablets / Cayston (aztreonam lysine) for the purpose of dispensing to patients presenting to community pharmacy with an NHS Scotland prescription.

1. Pharmacy Details

Alcura UK Ltd account number* _____

Pharmacy Name* _____

Address* _____

Postcode*: _____

Telephone number*: _____

Email address*: _____

2. Prescription details:

Sovaldi (sofosbuvir), Harvoni (ledipasvir/sofosbuvir), Cayston (aztreonam lysine) and Epclusa (sofosbuvir/velpatasvir) are only supplied to community pharmacies in Scotland in response to the receipt of valid NHS Scotland prescriptions specifying these medicines. The unique prescription number must be referenced to place an order for this product and volumes will be audited against prescriptions issued.

Prescription Number* (11 digits) _____

Number of boxes of Sovaldi (28 tablets) @ (£11,660.98 per box)	
Number of boxes of Harvoni (28 tablets) @ (£12,993.33 per box)	
Number of boxes of Cayston (84 vials) @ (£2,181.53 per box)	
Number of boxes of Epclusa (28 tablets) @ (£12993.33 per box)	

3. Pharmacist Declaration

I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate legal action may be taken. To enable the Common Services Agency to confirm the amount of products supplied to patients and for the purposes of prevention, detection, and investigation of crime, I consent to the disclosure of relevant information from this form including to and by NHS Scotland Practitioner & Counter Fraud Services. This declaration is made on behalf of the responsible pharmacist detailed below and the Community Pharmacy NHS Contractor

4. Signed confirmed by the responsible pharmacist

Full Name* (block capitals) _____

Signature* _____

Date* _____

GPhC Pharmacist registration number* _____

NHS Pharmacy contractor number* _____

***All sections to be fully completed - please telephone Alcura in the first instance if wishing to open a new account**

GC06/15b