

HIV REFERRAL FORM

FAX: 800-540-1852

Today's Date

CURRENT PATIENT
 NEW PATIENT

June 2017

Patient Name _____ SS# _____ DOB _____ Male Female
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
 Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

Insured's Name _____ Relation to Patient _____
 Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
 Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis Code _____ Diagnosis _____ Weight _____
 Testing? Yes No Results _____
 Patient currently on therapy? Yes No Date of next blood work _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg Sig: One tablet by mouth twice daily Qty _____ Refills _____
DESCOBY Sig: One tablet by mouth daily Qty _____ Refills _____
EMTRIVA 200mg capsule 10mg/mL solution
 Sig: _____ Qty _____ Refills _____
EPIVIR 100mg 150mg 300mg 5mg/mL 10mg/mL
 Sig: _____ Qty _____ Refills _____
EPZICOM Sig: One tablet by mouth daily Qty _____ Refills _____
RETROVIR 100mg 300mg 10mg/mL
 Sig: _____ Qty _____ Refills _____
TRIZIVIR 300/150/300mg
 Sig: One tablet by mouth twice daily Qty _____ Refills _____
TRUVADA 100/150mg 133/200mg 167/250mg 200/300mg
 Sig: One tablet by mouth daily Qty _____ Refills _____
VIDEX EC 125mg 200mg 250mg 400mg
 Sig: _____ Qty _____ Refills _____
VIREAD 150mg 200mg 250mg 300mg 40mg/gm powder
 Sig: _____ Qty _____ Refills _____
ZERIT 15mg 20mg 30mg 40mg 1mg/ml
 Sig: _____ Qty _____ Refills _____
ZIAGEN 300mg 20mg/ml
 Sig: _____ Qty _____ Refills _____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg 100mg/ml
 Sig: _____ Qty _____ Refills _____
CRIVIVAN 200mg 400mg
 Sig: _____ Qty _____ Refills _____
EVOTAZ Sig: One tablet by mouth daily with food Qty _____ Refills _____
INVIRASE 200mg 500mg
 Sig: _____ Qty _____ Refills _____
KALETRA 100mg/25mg 200mg/50mg 80mg/20mg solution
 Sig: _____ Qty _____ Refills _____
LEXIVA 700mg 50mg/ml
 Sig: _____ Qty _____ Refills _____
NORVIR 100mg tab 100mg cap 80mg/ml solution
 Sig: _____ Qty _____ Refills _____
PRECOBIX Sig: One tablet by mouth daily with food Qty _____ Refills _____
PREZISTA 75mg 150mg 400mg 600mg 800mg 100mg/mL susp.
 Sig: _____ Qty _____ Refills _____
REYATAZ 150mg 200mg 300mg cap 50mg packet
 Sig: _____ Qty _____ Refills _____
VIRACEPT 250mg 625mg
 Sig: _____ Qty _____ Refills _____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT Sig: One tablet by mouth daily w/ normal-high calorie meal
 Qty _____ Refills _____
INTELENCE 25 mg 100mg 200mg
 Sig: _____ Qty _____ Refills _____
RESCRIPTOR
 Sig: Take 400mg by mouth three times a day Qty _____ Refills _____
SUSTIVA 600mg tab 50mg cap 200mg cap
 Sig: _____ Qty _____ Refills _____
VIRAMUNE 200mg 50mg/5ml
 Sig: _____ Qty _____ Refills _____
VIRAMUNE XR 100mg 400mg
 Sig: _____ Qty _____ Refills _____

OTHER MEDICATIONS

ATRIPLA Sig: One tab by mouth daily on empty stomach Qty _____ Refills _____
COMPLERA Sig: One tablet by mouth daily with food Qty _____ Refills _____
GENVOYA Sig: One tablet by mouth daily with food Qty _____ Refills _____
ISENTRESS 400mg 25mg chew 100mg chew 100mg packet
 Sig: _____ Qty _____ Refills _____
ODEFSEY Sig: One tablet by mouth daily with food Qty _____ Refills _____
STRIBILD Sig: One tablet by mouth daily with food Qty _____ Refills _____
TRIUMEQ Sig: One tablet by mouth daily Qty _____ Refills _____

HGH

SEROSTIM 4mg 5mg 6mg
 Sig: Inject _____ mg daily Qty _____ Refills _____

OTHER

Sig: _____
 Qty _____ Refills _____

FUSION INHIBITORS

FUZEON Sig: _____ Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing QuickRx Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Provider please fax completed referral form to **QuickRx Specialty Pharmacy** at **800-540-1852** Visit **www.QuickRxSpecialty.com** for online fillable forms.



NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH HIV/AIDS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- Patient name
- Patient Demographics (Address, Phone Number, DOB, etc...)
- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.
If the only card included is a medical card, please include local pharmacy information.
- MD name/NPI/Office contact/Phone number
- Drug indicated with refills
- MD signature and date on referral form
- CD4 count
- Is the patient co-infected HIV/Hep C?
- Previous therapy

Fax the requested documentation to (800) 540-1852
Toll Free: 1-800-496-6111 Direct Phone: (347) 691-3494

www.QuickRxSpecialty.com

