



HIV REFERRAL FORM

Start Date

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Ship To: Patient Office Other

1. Patient Information: Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. # _____
First Name Last Name
 Address: _____
Street City State Zip
 Primary phone number: _____ Alternate phone number: _____
 Caregiver: _____ Allergies: _____
 Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information: Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis ICD-9: 042 HIV/AIDS 079.53 HIV2 070.32 HBV (Chronic) 070.54 HCV (Chronic)
 New to current therapy? Yes No CD4: _____ Date: _____ HIV RNA: _____ Date: _____

3. Prescription Information:

Medication	QTY	Refills	Medication	QTY	Refills
<input type="checkbox"/> Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)			<input type="checkbox"/> Selzentry® (maraviroc)		
<input type="checkbox"/> Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empty stomach			<input type="checkbox"/> Stribild™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
<input type="checkbox"/> Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)			<input type="checkbox"/> Sustiva® (efavirenz)		
<input type="checkbox"/> Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food			<input type="checkbox"/> Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
<input type="checkbox"/> Crixivan® (indinavir) One tablet by mouth QD with a meal			<input type="checkbox"/> Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
<input type="checkbox"/> Edurant™ (rilpivirine) 25 mg One capsule by mouth QD			<input type="checkbox"/> Videx®EC (didanosine)		
<input type="checkbox"/> Emtrivia® (emtricitabine) 200 mg			<input type="checkbox"/> Viracept® (nelfinavir)		
<input type="checkbox"/> Epivir® (lamivudine)			<input type="checkbox"/> Viramune® (nevirapine) 200 mg		
<input type="checkbox"/> Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD			<input type="checkbox"/> Viramune®XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
<input type="checkbox"/> Fuzeon® (enfuvirtide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			<input type="checkbox"/> Viread® (tenofovir) 300 mg		
<input type="checkbox"/> Intelence® (entravirine)			<input type="checkbox"/> Zerit® (stavudine)		
<input type="checkbox"/> Invirase® (saquinavir)			<input type="checkbox"/> Ziagen® (avacavir) 300mg		
<input type="checkbox"/> Isentress® (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)			Other Medications:		
<input type="checkbox"/> Kaletra® (lopinavir/ritonavir) 200/50 mg			<input type="checkbox"/> Acyclovir		
<input type="checkbox"/> Laxiva® (fosamprenavir) 200/50 mg			<input type="checkbox"/> Bactrim® (TMC/SMZ)		
<input type="checkbox"/> Norvir® (ritonavir) 100 mg			<input type="checkbox"/> Bactrim®DS (TMP/SMZ)		
<input type="checkbox"/> Prezista®(darunavir)			<input type="checkbox"/> Dapsone		
<input type="checkbox"/> Rescriptor®(delavirdine)			<input type="checkbox"/> Diflucan® (fluconazole)		
<input type="checkbox"/> Retrovir®(zidovudine)			<input type="checkbox"/> Serostim® (somatropin)		
<input type="checkbox"/> Reyataz®(ztzanavir)			<input type="checkbox"/> Valtrex® (valacyclovir)		
<input type="checkbox"/>			<input type="checkbox"/> Zithromax® (azithromycin)		

4. Prescriber and Shipping Information:

Prescriber (print): _____ Office Contact: _____
 Preferred method of contact: phone fax email preferred contact persons email: _____
 Office Address: _____
 Phone: _____ fax: _____ NPI: _____ DEA: _____
 Prescriber's Signature: _____ Date: _____
 I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. **(NO STAMPS)**

5. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

6. Insurance Information: Please fax a copy of the insurance card (front & back)

Patient Signature: _____ Date: _____

*IMPORTANT NOTICE: this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.