HIV REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821
FAX: 877-526-8823

Start Date

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 ☐ 0.79.53 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
☐ Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)			☐ Selzentry® (maraviroc)		
☐ Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empty stomach			☐ Stribild™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
☐ Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)			☐ Sustiva® (efavirenz)		
☐ Complera ™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food			☐ Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
☐ Crixivan ® (indinavir) One tablet by mouth QD with a meal			☐ Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
☐ Edurant™ (rilpivirine) 25 mg One capsule by mouth QD			☐ Videx®EC (didanosine)		
☐ Emtrivia® (emtricitabine) 200 mg			☐ Viracept® (nelfinavir)		
☐ Epivir® (lamivudine)			☐ Viramune® (nevirapine) 200 mg		
☐ Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD			☐ Viramune®XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			☐ Viread® (tenofovir) 300 mg		
☐ Intelence® (entravirine)			☐ Zerit® (stavudine)		
☐ Invirase® (saquinavir)			☐ Ziagen® (avacavir) 300mg		
☐ Isentress® (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)			**Other Medications:**		
☐ Kaletra® (lopinavir/ritonavir) 200/50 mg			☐ Acyclovir		
☐ Laxiva® (fosamprenavir) 200/50 mg			☐ Bactrim® (TMC/SMZ)		
☐ Norvir® (ritonavir) 100 mg			☐ Bactrim®DS (TMP/SMZ)		
☐ Prezista®(darunavir)			☐ Dapsone		
☐ Rescriptor®(delavirdine)			☐ Diflucan® (fluconazole)		
☐ Retrovir®(zidovudine)			☐ Serostim® (somatropin)		
☐ Reyataz®(ztzanavir)			☐ Valtrex® (valacyclovir)		
☐			☐ 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.**