PATIENT REFERRAL / MEDICATION REQUEST – HIV / AIDS

Phone:
Fax:
Toll Free:

Today Date: _____ Anticipated Start Date: _____ Ship Meds to: ☐ Home ☐ Work ☐ Doctor's Office

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City/County: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Cell Phone: _____
DOB: _____ Caregiver: _____
Height: _____ Weight: _____ Email: _____
Allergies: _____

Insurance Information

Primary Insurance: _____ Pharmacy Benefit Manager (PBM): _____
Policy #: _____ Group #: _____ Insured: _____ Phone: _____
Medicare: ☐ Yes ☐ No If yes, provide #: _____ Medicaid: ☐ Yes ☐ No If yes, provide #: _____
Secondary Insurance: _____
Policy #: _____ Group #: _____ Insured: _____ Phone: _____

Physician Information

First Name: _____ Last Name: _____ ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Office Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____ NPI #: _____
License #: _____ UPIN #: _____ Medical Provider #: _____
Office Contact Name: _____ Email Address: _____ Phone: _____

Diagnosis	Clinic Information
☐ 042 HIV/AIDS ☐ Other: _____	CD4 Count: _____ Viral Load: _____ Date: _____

Prescription Information

(Please select and provide approximate days supply.)
P=preferred PG=preferred generic only (brand medical exception)

	Medication	Strength/Direction	Quantity	Refill
P	☐ Atripla			
	☐ Combivir			
	☐ Epzicom			
	☐ Trizivir			
P	☐ Truvada			
	NRTIs/NNTRIs			
P	☐ Emtriva			
P	☐ Epivir			
	☐ Intelence			
	☐ Rescriptor			
PG	☐ Retrovir (vidovudine)			
P	☐ Sustiva			
PG	☐ Videx EC (didanosine EC)			
P	☐ Viramune			
P	☐ Viread			
PG	☐ Zerit			
P	☐ Ziagen			
	Protease Inhibitors			
	☐ Aptivus			
P	☐ Crixivan			
P	☐ Invirase			
P	☐ Kaletra			
P	☐ Norvir			
	☐ Prezista			
P	☐ Reyetaz			
P	☐ Viracept			
	Integrase Inhibitors			
	☐ Insentress			
	Entry Inhibitors			
	☐ Selzentry			
	Fusion Inhibitors			
	☐ Fuzeon			
	Growth Hormones			
	☐ Serostim			
	Other Meds			
	☐			

Prescriber's Signature (Required by Law): _____ Date: _____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____