

**HIV REFERRAL FORM**

3100 MacCorkle Avenue S.E. | Suite 100  
 Charleston, WV 25304  
 TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

**CURRENT PATIENT**  
 **NEW PATIENT**

July 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"/>	# _____

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 \_\_\_\_\_  
**DESCOXY** 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 \_\_\_\_\_  
**CRIVAN**  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 \_\_\_\_\_

**FUSION INHIBITORS**

**FUZEON** Sig: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**OTHER** \_\_\_\_\_  
 Sig: \_\_\_\_\_  
 Qty \_\_\_\_\_ Refills \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Med Center 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.

Please fax completed referral form to **Med Center Specialty Pharmacy at 304-344-0655** Visit **www.MEDCENTERSPECIALTYPHARMACY.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 (304) 344-0655***  
***Toll Free: 1-855-633-5633 Direct Phone: (304) 344-8021***  
***MedCenterSpecialtyPharmacy.com***

**MED CENTER**  
**SPECIALTY PHARMACY**  
*Dedicated to Improving Our Patients' Health*  
Part of The Elwyn Pharmacy Group

