



HIV/AIDS Referral Form

www.premierchoicepharmacy.com
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Patient Information

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State	Zip
Social Security #	Date of Birth	Gender (M/F)	Weight	Height	Allergies		
Today's Date	Date Meds Needed		Emergency Contact/Phone		Primary Caregiver/Phone		

Healthcare Provider Information *Indicates Required Field

Practice/Facility Name		Physician First and Last Name*		Phone*	Fax	
Address*			City*		State*	Zip*
Physician NPI#*		Physician DEA#		Physician State License #		
Nurse/ Key Contact		Phone Number		Email		

Diagnosis/Clinical Information: Please Fax a Copy of Patient's Insurance Card (Front and Back)

Diagnosis: 042 HIV/AIDS 079.53 HIV-2 070.32 HBV (Chronic) 070.54 HCV (Chronic) New to current therapy? Yes No

CD4 Count:----- Date:----- HIV RNA:----- Date:-----

Medication	Strength	Sig	Qty	Refills	Medication	Strength	Sig	Qty	Refills
<input type="checkbox"/> Aptivus®	250mg caps	2 capsules by mouth BID (Q12H)			<input type="checkbox"/> Stribild®	150/150/200/300mg tabs	One tablet by mouth QD with food		
<input type="checkbox"/> Atripla®	600/300/200mg tabs	1 tablet by mouth QD on an empty stomach			<input type="checkbox"/> Sustiva®	600mg tabs	Take one tablet at bedtime		
<input type="checkbox"/> Combivir®	150mg/300mg tabs	One tablet by mouth BID (Q12H)			<input type="checkbox"/> Tivicay®	50mg tabs	Take -----tabs----- x daily		
<input type="checkbox"/> Emtriva®	200mg caps	One capsule by mouth QD			<input type="checkbox"/> Triumeq®				
<input type="checkbox"/> Epivir®	----- mg tabs	One tablet----- x daily			<input type="checkbox"/> Trizivir®	300/150/300mg tabs	One tablet by mouth BID (Q12H)		
<input type="checkbox"/> Epzicom®	600mg/300mg tabs	One tablet by mouth QD			<input type="checkbox"/> Truvada®	200mg/300mg tabs	One tablet by mouth QD		
<input type="checkbox"/> Invirase®					<input type="checkbox"/> Viracept®				
<input type="checkbox"/> Isentress®	400mg tabs	One tablet by mouth BID (Q12H)			<input type="checkbox"/> Viramune®	200mg tabs			
<input type="checkbox"/> Kaletra®	200mg/50mg tabs	Take----tabs----x daily			<input type="checkbox"/> Viramune XR®	400mg tabs	One tablet by mouth QD		
<input type="checkbox"/> Norvir® caps	100mg caps	Take----tabs----x daily			<input type="checkbox"/> Viread®	300mg tabs	Take ----- daily		
<input type="checkbox"/> Norvir® tabs	100mg tabs	Take---tabs---x daily			<input type="checkbox"/> Zerit®				
<input type="checkbox"/> Prezista®	----- mg tabs	Take---tabs---x daily			<input type="checkbox"/> Ziagen®	300mg tabs	Take ----- tabs----- x daily		
<input type="checkbox"/> Retrovir®	----- mg tabs	Take---tabs---x daily			<input type="checkbox"/> Complera®	200/25/300mg tabs	One tablet by mouth QD with food		
<input type="checkbox"/> Reyataz®	----- mg tabs	Take---tabs---x daily							
<input type="checkbox"/> Selzentry®	----- mg tabs	Take---tabs---x daily							

When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature: _____ DAW (Dispense as Written) Date ___/___/___ I authorize Premier Choice Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third-party payer.