ameripharma SPECIALTY CARE

HIV Referral Form

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient + Insurance Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis Code: ☐ B20 HIV ☐ B18.0 HBV with delta agent (Chronic) ☐ B18.1 HBV without delta agent (Chronic) ☐ B18.2 HCV (Chronic)

New to current therapy? ☐ Yes ☐ No CD4: _____ Date: _____ HIV RNA: _____ Date: _____

Comorbidities: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescriptions

Medication	QTY	Refills
☐ **Aptivus®** (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)		
☐ **Atripla®** (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empy stomach		
☐ **Biktarvy®** (bictegravir/emtricitabine/tenofovir alafenamide) One tablet by mouth once a day with or without food		
☐ **Combivir®** (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours		
☐ **Complera™** (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food		
☐ **Crixivan®** (indinavir) One tablet by mouth QD with a meal		
☐ **Descovy®** (emtricitabine/tenofovir alafenamide) One tablet by mouth once a day with or without food		
☐ **Edurant™** (rilpivirine) 25 mg. One capsule by mouth QD		
☐ **Emtrivia®** (emtricitabine) 200 mg		
☐ **Epivir®** (lamivudine)		
☐ **Epzicom®** (abacavir/lamivudine) 600/300 mg One tablet by mouth QD		
☐ **Fuzeon®** (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
☐ **Fuzeon®** (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
☐ **Intelence®** (entravirine)		
☐ **Invirase®** (saquinavir)		
☐ **Isentress®** (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)		
☐ **Kaletra®** (lopinavir/ritonavir) 200/50 mg		
☐ **Laxiva®** (fosamprenavir) 200/50 mg		
☐ **Norvir®** (ritonavir) capsules 100 mg		
☐ **Norvir®** (ritonavir) tablets 100 mg		
☐ **Prezista®** (darunavir)		
☐ **Rescriptor®** (delavirdine)		
☐ **Retrovir®** (zidovudine)		
☐ **Reyataz®** (atazanavir)		

Medication	QTY	Refills
☐ **Selzentry®** (maraviroc)		
☐ **Stribid™** (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
☐ **Sustiva®** (efavirenz)		
☐ **Trizivir®** (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
☐ **Truvada®** (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
☐ **Videx® EC** (didanosine)		
☐ **Viracept®** (nelfinavir)		
☐ **Viramune®** (nevirapine) 200 mg		
☐ **Viramune® XR™** (nevirapine ER) 400 mg One tablet by mouth QD		
☐ **Viread®** (tenofovir) 300 mg		
☐ **Zerit®** (stavudine)		
☐ **Ziagen®** (avacavir) 300 mg		
Other Medications		
☐ **Acylovir**		
☐ **Bactrim®** (TMC/SMZ)		
☐ **Bactrim® DS** (TMP/SMZ)		
☐ **Dapsone**		
☐ **Diflucan®** (fluconazole)		
☐ **Serostim®** (somatropin)		
☐ **Valtrex®** (valacyclovir)		
☐ **Zithromax®** (azithromycin)		

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form