Pharmax SPECIALTY PHARMACY

HIV REFERRAL FORM

TEL 813.880.2500
FAX 813.880.2501
TOLL FREE 1.866.880.2507

PATIENT INFORMATION

Name:_____ Address:_____ _____ _____ Phone:_____
SSN:_____ DOB:_____ Sex: _____
Weight:_____ Height:_____ Allergies:_____ Ship to: ☐Patient ☐Clinic

INSURANCE

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____
Group:_____ (Please attach copies of insurance cards.)

DIAGNOSIS

☐B20 HIV ☐R64 Cachexia ☐B18.1 Hepatitis B ☐B18.2 Chronic HCV ☐HIV infected patients with Abdominal Lipodystrophy ☐Other
Prior failed medications: _____ Start Date:_____ End Date:_____
Reason for DC:_____
Current Medications:_____

LAB RESULTS

CD4 COUNT: _____ HIV RNA: _____ HGB/HCT: _____ SCR: _____ WBC/ANC:_____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Qty.	Refill
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)				
Emtriva				
Epivir				
Retrovir				
Videx Ec				
Zerit				
Ziagen				
Nucleotide Reverse Transcriptase Inhibitors (NRTIs)				
Viread				
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)				
Endurant				
Intelence				
Rescriptor				
Sustiva				
Virammune				
Virammune Xr				
Protease Inhibitors (PIs)				
Aptivus				
Crixivan				
Invirase				
Kaletra				
Lexiva				
Norvir				
Prezista				
Reyataz				
Viracept				

Medication	Dose	Directions	Qty.	Refill
Integrase Strand Transfer Inhibitors (ISTIs)				
Isentress				
Tivicay				
Viteka				
Entry Inhibitors (CCR5 Antagonists)				
Fuzeon				
Salzentry				
Combination Antiretrovirals				
Atripla				
Combivir				
Complera				
Descovy				
Epzicom				
Genvoya				
Prezcobix				
Stribild				
Triumeq				
Trizivir				
Truvada				
Other Medications				

PRESCRIBER INFORMATION

Physicain Name:_____ Address:_____
State License#:_____ NPI:_____ DEA:_____
Phone #:_____ Fax #:_____ Office Contact Name /Number:_____
Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.