Elwyn SPECIALTY CARE Rx
Part of The Elwyn Pharmacy Group
Dedicated to Improving Our Patients' Health

June 2017

HIV REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

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

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

☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____

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 _____
DESCOVY 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 _____

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 _____

FUSION INHIBITORS

FUZEON Sig:_____ Qty _____ Refills _____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS ☐ 250mg ☐ 100mg/ml
Sig:_____ Qty _____ Refills _____
CRIXIVAN ☐ 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 _____
PREZCOBIX 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 _____

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 _____

OTHER

_____
Sig _____
Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care 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 **Elwyn Specialty Care** at **610-545-6030** Visit **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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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 (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) *Direct Phone: (610) 545-6040*

ElwynSpecialtyCare.com

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