Elwyn SPECIALTY CARE
A BIOMATRIX Company
FEB 2018

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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