benevere PHARMACY

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TODAY'S DATE:_____

☐ NEW PATIENT ☐ CURRENT PATIENT

HIV Referral Form

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
DOB _____ SSN _____
Drug Allergies _____ ☐ Male ☐ Female
Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____
NPI# _____ Tax ID _____
Practice Name _____
Address _____ Suite _____
City _____ State _____ Zip _____
Office Phone _____ Fax _____
Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____
Policy # _____ Group _____
Insurance Phone _____
Prescription Drug Coverage: Company _____
RXGRP# _____ RXBIN# _____

Secondary Insurance (if applicable) _____
Policy # _____ Group _____
Insurance Phone _____
Phone _____
PCN/ID# *(if available)* _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis: ☐ B24 AIDS, unspecified ☐ B20 HIV infection Date Diagnosed: _____ CD4 Count: _____ Viral Load: _____ Date: _____
Co-infection: ☐ Yes ☐ No _____ Treatment of Co-Infection: _____
New to therapy: ☐ Yes ☐ No If no, date therapy began: _____ Scr: _____ Date: _____ Please attach a list of patient's current medications.

PREVIOUS ANTIRETROVIRAL THERAPY

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing
Antiretroviral Drug Resistance:		

MEDICATION

Fixed Dose Combinations		NRTI	NNRTI	Protease Inhibitors	Integrase Inhibitors	Misc.
☐ Atripla	☐ Kaletra	☐ Emtriva	☐ Edurant	☐ Aptivus	☐ Isentress	☐ Fuzeon 90mg Inj
☐ Biktarvy	☐ Odefsey	☐ Epivir	☐ Intelence	☐ Invirase	☐ Tivicay	☐ Prezcobix
☐ Cimduo	☐ Prezcobix	☐ Retrovir	☐ Pifeltro	☐ Lexiva		☐ Selzentry
☐ Combivir	☐ Stribild	☐ Videx EC	☐ Sustiva	☐ Norvir		☐ Trogarzo
☐ Complera	☐ Symfi	☐ Viread	☐ Viramune	☐ Prezista		
☐ Descovy	☐ Symfi Lo	☐ Ziagen	☐ Viramune XR	☐ Reyataz		
☐ Epzicom	☐ Symtuza					
☐ Evotaz	☐ Triumeq					
☐ Genvoya	☐ Trizivir					
☐ Juluca	☐ Truvada					

Prescription: Dose: _____ Quantity: _____ Refills: _____

Directions: ☐ Take __ tablet(s) daily. ☐ Take __ tablet(s) twice daily. ☐ With Food ☐ On Empty Stomach
☐ Other: _____

Supplies Needed ☐ Syringes/Needles ☐ Swabs ☐ Sharps Container
☐ Other _____

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training
Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere 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 _____