

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 _____ Secondary Insurance (if applicable) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance Phone _____ Insurance Phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ 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.
<input type="checkbox"/> Atripla	<input type="checkbox"/> Kaletra	<input type="checkbox"/> Emtriva	<input type="checkbox"/> Edurant	<input type="checkbox"/> Aptivus	<input type="checkbox"/> Isentress	<input type="checkbox"/> Fuzeon 90mg Inj
<input type="checkbox"/> Biktarvy	<input type="checkbox"/> Odefsey	<input type="checkbox"/> Epivir	<input type="checkbox"/> Intelence	<input type="checkbox"/> Invirase	<input type="checkbox"/> Tivicay	<input type="checkbox"/> Selzentry
<input type="checkbox"/> Cimduo	<input type="checkbox"/> Prezcoibix	<input type="checkbox"/> Retrovir	<input type="checkbox"/> Pifeltro	<input type="checkbox"/> Lexiva		<input type="checkbox"/> Trogarzo
<input type="checkbox"/> Combivir	<input type="checkbox"/> Stribild	<input type="checkbox"/> Videx EC	<input type="checkbox"/> Sustiva	<input type="checkbox"/> Norvir		<input type="checkbox"/> Tybost
<input type="checkbox"/> Complera	<input type="checkbox"/> Symfi	<input type="checkbox"/> Viread	<input type="checkbox"/> Viramune	<input type="checkbox"/> Prezista		
<input type="checkbox"/> Delstrigo	<input type="checkbox"/> Symfi Lo	<input type="checkbox"/> Ziagen	<input type="checkbox"/> Viramune XR	<input type="checkbox"/> Reyataz		
<input type="checkbox"/> Descovy	<input type="checkbox"/> Symtuza					
<input type="checkbox"/> Dovato	<input type="checkbox"/> Temixys					
<input type="checkbox"/> Epzicom	<input type="checkbox"/> Trumeq					
<input type="checkbox"/> Evotaz	<input type="checkbox"/> Trizivir					
<input type="checkbox"/> Genvoya	<input type="checkbox"/> Truvada					
<input type="checkbox"/> Juluca						

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 _____

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