benevere PHARMACY
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beneverepharmacy.com

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 _____ Secondary Insurance (if applicable)_____
Insurance Phone_____ Insurance Phone_____

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	☐ Selzentry
☐ Cimduo	☐ Prezcobix	☐ Retrovir	☐ Pifeltro	☐ Lexiva		☐ Trogarzo
☐ Combivir	☐ Stribild	☐ Videx EC	☐ Sustiva	☐ Norvir		☐ Tybost
☐ Complera	☐ Symfi	☐ Viread	☐ Viramune	☐ Prezista		
☐ Delstrigo	☐ Symfi Lo	☐ Ziagen	☐ Viramune XR	☐ Reyataz		
☐ Descovy	☐ Symtuza					
☐ Dovato	☐ Temixys					
☐ Epzicom	☐ Triumeq					
☐ Evotaz	☐ Trizivir					
☐ Genvoya	☐ Truvada					
☐ 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

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS)_____ Date _____