PHARMACY SPECIALIST
Your Partner in HealthCare

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Livonia, MI 48154

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Infectious Disease Referral Form

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ____ PATIENT: ____ OFFICE: ___ OTHER: _____

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Social Security #: _____

Date of Birth: _____ Sex: _____ M _____ F

PRESCRIBER INFORMATION

Prescriber Name: _____

DEA #: _____ NPI#: _____

Group: _____

Address: _____

City, State, Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Contact Person: _____

INSURANCE INFORMATION: (please copy and attach the front and back of insurance and prescription drug card)

CLINICAL INFORMATION - STATEMENT OF MEDICAL NECESSITY

Diagnosis: ____ 042 HIV/AIDS ____ 070.32 Chronic Hepatitis B ____ 070.54 Chronic Hepatitis C ____ other _____

CD4/T-cell: _____ HIV RNA: _____ HCV genotype: _____ Viral Load: _____ (copies or IU/ml) ALT: _____ Liver Biopsy Results: _____

Weight: _____ BLOOD RESULTS-Date Drawn: _____ Hgb/Hct: _____ WBC: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
NRTIs/NNRTIs				
___Edurant	25mg	_____	_____	_____
___Emtriva	200mg	_____	_____	_____
___Epivir	_____	_____	_____	_____
___Intelence	100mg	_____	_____	_____
___Retrovir	300mg	_____	_____	_____
___Sustiva	_____	_____	_____	_____
___Videx	_____	_____	_____	_____
___Viramune	200mg	_____	_____	_____
___Viread	300mg	_____	_____	_____
___Zerit	_____	_____	_____	_____
___Ziagen	300mg	_____	_____	_____
Protease Inhibitors				
___Aptivus	250mg	_____	_____	_____
___Crixivan	_____	_____	_____	_____
___Invirase	_____	_____	_____	_____
___Kaletra	_____	_____	_____	_____
___Lexiva	700mg	_____	_____	_____
___Norvir	100mg	_____	_____	_____
___Prezista	300mg	_____	_____	_____
___Reyataz	_____	_____	_____	_____
___Viracept	_____	_____	_____	_____
Combinations				
___Atripla	300/200/600	_____	_____	_____
___Combivir	300/150	_____	_____	_____
___Complera	200/25/300	_____	_____	_____
___Epzicom	600/300	_____	_____	_____
___Stribild	150/150/200/300	_____	_____	_____
___Trizivir	300/150/300	_____	_____	_____
___Truvada	300/200	_____	_____	_____
Fusion Inhibitor				
___Fuzeon	90mg kit	_____	_____	_____
Integrase Inhibitor/CCR5 Inhibitor				
___Isentress	400mg	_____	_____	_____
___Selzentry	_____	_____	_____	_____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Interferon				
___Pegasys**	180ug	_____	_____	_____
**Convenience pack will be given unless you check off ___vial here				
___PEG Intron**		_____	_____	_____
**Redipen will be given unless you check off ___vial here				
	___150ug/0.5ml			
	___120ug/0.5ml			
	___80ug/0.5ml			
	___50ug/0.5ml			
___Infergen	_____	_____	_____	_____
___Ribavirin tabs	200mg	_____	_____	_____
___Ribavirin caps	200mg	_____	_____	_____
Hepatitis B				
___Baraclude	_____	_____	_____	_____
___Epivir HBV	100mg	_____	_____	_____
___Hepsera	10mg	_____	_____	_____
___Tyzeka	600mg	_____	_____	_____
Other Meds				
___Bactrim	_____	_____	_____	_____
___Diflucan	_____	_____	_____	_____
___Zithromax	_____	_____	_____	_____
___Vfend	_____	_____	_____	_____
___Aranesp pfs	_____	_____	_____	_____
___Neulasta pfs	_____	_____	_____	_____
___Neupogen pfs	_____	_____	_____	_____
___Procrit	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_ By signing this form and utilizing our services, you are authorizing Pharmacy Specialist and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature **Date**