Elwyn SPECIALTY CARE
Dedicated to Improving Our Patients' Health

HIV PRESCRIPTION REFERRAL FORM

54 Conchester Road Glen Mills, PA 19342
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ____ Middle Name ____ Last Name ____ DOB ____ Weight ____ ☐ Male ☐ Female

Street Address ____ Apt # ____ City ____ State ____ Zip ____

Daytime Tel ____ Evening Tel ____ Cell ____ Email ____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ____

ICD-9 Diagnosis ____ Weight ____ Allergies ____ CD4 ____ Viral Load ____

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# ____

Prescriber's Name ____ Office Contact ____

Street Address ____ Suite # ____ City ____ State ____ Zip ____

Tel ____ Fax ____ Email ____

License# ____ NPI# ____ UPIN# ____ DEA# ____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg
Tabs | Sol #____ Refill x ____ Sig ____

EMTRIVA 200mg
Caps #____ Refill x ____ Sig ____

EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

EPZICOM 600/300mg
Tabs #____ Refill x ____ Sig ____

RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

TRIZIVIR 300/150/300mg
Tabs | Sol #____ Refill x ____ Sig ____

TRUVADA 200/300mg
Tabs | Sol #____ Refill x ____ Sig ____

VIDEX EC 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd #____ Refill x ____ Sig ____

VIREAD 300mg
Tabs | Sol #____ Refill x ____ Sig ____

ZERIT
15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol #____ Refill x ____ Sig ____

ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

FUSION INHIBITORS

FUZEON 90mg Refill x ____ Sig ____

OTHER MEDICATIONS

ATRIPLA Tabs #____ Refill x____ Sig ____
COMPLERA Tabs #____ Refill x____ Sig ____
ISENTRESS 400 mg Tabs #____ Refill x____ Sig ____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps #____ Refill x ____ Sig ____

CRIXIVAN 200mg 333mg 400mg
Caps #____ Refill x ____ Sig ____

INVIRASE 200mg 500mg
Caps | Sol #____ Refill x ____ Sig ____

KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #____ Refill x ____ Sig ____

LEXIVA 700mg Oral Susp. 50mg/ml
Tabs #____ Refill x ____ Sig ____

NORVIR 100mg 80mg/ml
Caps | Sol #____ Refill x ____ Sig ____

PREZISTA 75mg 150mg 400mg 600mg
Tabs | Sol #____ Refill x ____ Sig ____

REYATAZ 100mg 150mg 200mg 300mg
Caps #____ Refill x ____ Sig ____

VIRACEPT 250mg 625mg
Tabs | Pwd #____ Refill x ____ Sig ____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs #____ Refill x ____ Sig ____

INTELENCE 100 mg 200mg
Tabs #____ Refill x ____ Sig ____

RESCRIPTOR 200mg
Caps #____ Refill x ____ Sig ____

SUSTIVA 50mg 200mg 600mg
Tabs | Caps #____ Refill x ____ Sig ____

VIRAMUNE 200mg 50mg/5ml
Tabs | Sol #____ Refill x ____ Sig ____

ADDITIONAL MEDICATIONS

Other ____ Tabs #____ Refill x ____ Sig ____ Other ____ Tabs #____ Refill x ____ Sig ____

By signing this form and utilizing our services, you are authorizing Elwyn Specialty 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 Pharmacy** at **610-545-6030** Visit us at **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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