aleracare
advanced specialty pharmacy

Infectious Disease
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis: ◯ B20 HIV/AIDS ◯ B18.1 Chronic Hepatitis B ◯ B18.2 Chronic Hepatitis C ◯ Other:_____

CD/4/Ty cell: _____HIV RNA: _____HCV genotype: _____Viral Load: _____(Copies or IU/ml) ALT _____Liver Biopsy

Results:_____ BLOOD RESULTS Date Drawn: _____Hgb/Hct: _____WBC: _____

	Directions	Qty	Refills
NRTIS/NNRTIS			
◯ EDURANT			
◯ EMTRIVA			
◯ EPIVIR			
◯ INTELENCE			
◯ RESCIPTOR			
◯ RETROVIR			
◯ SUSTIVA			
◯ VIDEX			
◯ VIRAMUNE			
◯ VIREAD			
◯ ZENRIT			
◯ ZIAGEN			
PROTEASE INHIBITORS			
◯ APTIVUS			
◯ INVIRASE			
◯ KALETRA			
◯ LEXIVA			
◯ NORVIR			
◯ PREZISTA			
◯ REYATAZ			
◯ VIRACEPT			

	Directions	Qty	Refills
COMBINATIONS			
◯ ATRIPLA			
◯ COMBIVIR			
◯ COMPLERA			
◯ EPZICOM			
◯ STRIBILD			
◯ TRIZIVIR			
◯ TRUVADA			
INTEGRASE INHIBITORS/CCR5 I			
◯ ISENTRESS			
◯ SELZENTRY			
◯ TIVICAY			
OTHER MEDS			

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**