aleracare
advanced specialty pharmacy

Infectious Disease
Referral Form

Patient Information

Patient Name: DOB:
Address:
City: State: Zip:
Phone: Alternate Phone: SSN:
Height: Weight: Allergies:
Emergency Contant: Phone:

Prescriber Information

Prescriber's Name:
NPI#:
DEA#: License#:
Address:
Phone: Fax:
Contact Person:

Is the patient pregnant, planning a pregnancy or nursing: Yes No

Does the patient need interpreter services: Yes No

Documentation (Required)

Insurance Card (front and back) Current Medications History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

Hep B Test HIV HIV co-infection Other: ______________________________

Client Considerations

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

	Directions	Qty	Refills		Directions	Qty	Refills
NRTIS/NNRTIS				***COMBINATIONS***			
EDURANT				**ATRIPLA**			
EMTRIVA				**COMBIVIR**			
EPIVIR				**COMPLERA**			
INTELENCE				**EPZICOM**			
RESCIPTOR				**STRIBILD**			
RETROVIR				**TRIZIVIR**			
SUSTIVA				**TRUVADA**			
VIDEX				***INTEGRASE INHIBITORS/CCR5 I***			
VIRAMUNE				**ISENTRESS**			
VIREAD				**SELZENTRY**			
ZENRIT				**TIVICAY**			
ZIAGEN				***OTHER MEDS***			
PROTEASE INHIBITORS							
APTIVUS							
INVIRASE							
KALETRA							
LEXIVA							
NORVIR							
PREZISTA							
REYATAZ							
VIRACEPT							

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**