

Lifeline Specialty Pharmacy

HIV Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043



Send your Rx to:

Fax Number: 410-203-1515
Phone Number: 410-203-1010

Toll Free Number:
1-833-4-LIFELINE

NPI: 1568975464

If you have questions or concerns, please contact us.

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

2: Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Primary Prescription Insurance _____ Rx Bin _____
 Rx PCN _____ Patient ID/Policy Number _____ Patient Rx Group Number _____

3: Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

4: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: B20 HIV/AIDS B18.0 Hepatitis B B18.2 Hepatitis C (Chronic) B18.0 Hepatitis B R64 Cachexia (HIV Wasting)
 ICD-10 Code & Description _____

5: Prescription Information

NRTIs					Combination Antiretrovirals				
Drug	Strength	Sig	QTY	Refills	Drug	Strength	Sig	QTY	Refills
<input type="checkbox"/> Edurant					<input type="checkbox"/> Atripla	300/200/600			
<input type="checkbox"/> Emtriva	200mg				<input type="checkbox"/> Biktravy	50/200/25			
<input type="checkbox"/> Efavir					<input type="checkbox"/> Combivir	300/150			
<input type="checkbox"/> Retrovir					<input type="checkbox"/> Complera	300/200/25			
<input type="checkbox"/> Videx EC					<input type="checkbox"/> Descovy	200/25			
<input type="checkbox"/> Viread					<input type="checkbox"/> Epizicom	600/300			
<input type="checkbox"/> Zerit	300mg				<input type="checkbox"/> Genvoia	150/150/200/10			
<input type="checkbox"/> Ziagen					<input type="checkbox"/> Juluca	50/25			
NNRTIs					<input type="checkbox"/> Odefsey	200/25/25			
<input type="checkbox"/> Intelence	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg				<input type="checkbox"/> Stribild	150/150/200/300			
<input type="checkbox"/> Sustiva					<input type="checkbox"/> Trizivir	300/150/300			
<input type="checkbox"/> Viramune XR					<input type="checkbox"/> Triumeq	600/50/300			
Entry Inhibitors					Protease Inhibitors				
<input type="checkbox"/> Fuzeon	90mg vial				<input type="checkbox"/> Aptivus	250mg			
<input type="checkbox"/> Selzentry					<input type="checkbox"/> Invirase				
Integrase Inhibitors					<input type="checkbox"/> Kaletra	200/50			
<input type="checkbox"/> Isentress	400mg				<input type="checkbox"/> Lexiva	700mg			
<input type="checkbox"/> Isentress HD	600mg				<input type="checkbox"/> Norvir tablet	100mg			
<input type="checkbox"/> Tivicay	50mg				<input type="checkbox"/> Prezcoibix	800/150mg			
<input type="checkbox"/> Vitekta	<input type="checkbox"/> 85mg <input type="checkbox"/> 150mg				<input type="checkbox"/> Prezista				
Other Medications					<input type="checkbox"/> Viracept				
<input type="checkbox"/> Tybost	150mg				<input type="checkbox"/> Truvada	200/300			
<input type="checkbox"/> Truvada (PrEP)	200/300								

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

_____ Date: _____

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

I authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. **IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____