Lifeline Specialty Pharmacy

HIV Referral Form

6304 Woodside Ct, Ste 100
Columbia, MD 21046

Send your Rx to: **Phone: 1-833-4-LIFELINE (1-833-454-3354)**
Fax: 1-833-785-4461

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**
☐ Edurant					☐ Atripla	300/200/600			
☐ Emtriva	200mg				☐ Biktravy	50/200/25			
☐ Epivir					☐ Combivir	300/150			
☐ Retrovir					☐ Complera	300/200/25			
☐ Videx EC					☐ Descovy	200/25			
☐ Viread					☐ Epizicom	600/300			
☐ Zerit	300mg				☐ Genvoya	150/150/200/10			
☐ Ziagen					☐ Juluca	50/25			
NNRTIs					☐ Odefsey	200/25/25			
☐ Intelence	☐ 100mg ☐ 200mg				☐ Stribild	150/150/200/300			
☐ Sustiva					☐ Trizivir	300/150/300			
☐ Viramune XR					☐ Triumeq	600/50/300			
Entry Inhibitors					Truvada	300/200			
☐ Fuzeon	90mg vial				*Protease Inhibitors*				
☐ Selzentry					☐ Apitivus	250mg			
Integrase Inhibitors					☐ Invirase				
☐ Isentress	400mg				☐ Kaletra	200/50			
☐ Isentress HD	600mg				☐ Lexiva	700mg			
☐ Tivicay	50mg				☐ Norvir tablet	100mg			
☐ Vitekta	☐ 85mg ☐ 150mg				☐ Prezcobix	800/150mg			
Other Medications					☐ Prezista				
☐ Tybost	150mg				☐ Viracept				
☐ Truvada (PrEP)	200/300				☐ Truvada	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

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:__________