Amber PHARMACY

HIV/AIDS Referral Form

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Temporary Address or Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Date of Birth	Gender (M/F)	Weight	Height	Allergies

Today's Date	Date Meds Needed	Emergency Contact/Phone	Primary Caregiver/Phone

Healthcare Provider Information: **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Physician UPIN#	Physician DEA#	Physician State License #

Nurse/Key Contact	Phone or Pager Number	Email

Diagnosis/Clinical Information: *Please Fax a Copy of Patient's Insurance Card (Front and Back)*

Diagnosis: ❑ 042 HIV/AIDS ❑ 079.53 HIV-2 ❑ 070.32 HBV (Chronic) ❑ 070.54 HCV (Chronic) New to current therapy? ❑ **Yes** ❑ **No**

CD4 Count: _____ Date: _____ HIV RNA: _____ Date: _____

Medication	Strength	Sig	Qty	Refills
❑ **Aptivus®**	250mg caps	Two capsules by mouth BID (Q 12 hours)		
❑ **Atripla®**	600/300/200mg tabs	One tablet by mouth QD on an empty stomach		
❑ **Combivir®**	150mg/300mg tabs	One tablet by mouth BID (Q 12 hours)		
❑ **Complera®**	200/25/300mg tabs	One tablet by mouth QD with food		
❑ **Emtriva®**	200mg caps	One capsule by mouth QD		
❑ **Epivir®**	_____mg tabs	One tablet _____ x daily		
❑ **Epzicom®**	600mg/300mg tabs	One tablet by mouth QD		
❑ **Invirase®**				
❑ **Isentress®**	400mg tabs	One tablet by mouth BID (Q 12 hours)		
❑ **Kaletra®**	200mg/50mg tabs	Take_____ tabs____x daily		
❑ **Norvir® caps**	100mg caps	Take_____ caps____x daily		
❑ **Norvir® tabs**	100mg tabs	Take_____ tabs____x daily		
❑ **Prezista®**	_____mg tabs	Take_____ tabs____x daily		
❑ **Retrovir®**	_____mg tabs	Take_____ tabs____x daily		
❑ **Reyataz®**	_____mg caps	Take_____ caps____x daily		
❑ **Selzentry®**	_____mg tabs	Take_____ tabs____x daily		

Medication	Strength	Sig	Qty	Refills
❑ **Stribild®**	150/150/200/300mg tabs	One tablet by mouth QD with food		
❑ **Sustiva®**	600mg tabs	Take one tablet at bedtime		
❑ **Tivicay®**	50mg tabs	Take_____ tabs____x daily		
❑ **Triumeq®**				
❑ **Trizivir®**	300/150/300mg tabs	One tablet by mouth BID (Q 12 hours)		
❑ **Truvada®**	200mg/300mg tabs	One tablet by mouth QD		
❑ **Viracept®**				
❑ **Viramune®**	200mg tabs			
❑ **Viramune XR®**	400mg tabs	One tablet by mouth QD		
❑ **Viread®**	300mg tabs	Take_____daily		
❑ **Zerit®**				
❑ **Ziagen®**	300mg tabs	Take_____ tabs____x daily		
❑				
❑				
❑				
❑				

*****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards*****

Physician Signature:_____ ❑ **DAW** (Dispense as Written) **Date** ____/____/____

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