BIOMATRIX SpRx

HIV REFERRAL FORM

TODAY'S DATE _____

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089

☐ **BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595

☐ **BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089

☐ **Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

☐ **Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030

☐ **Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324

☐ **Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805

☐ **Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655

☐ **MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS# _____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____
☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____
☐ _____ # _____ ☐ _____ # _____ ☐ _____ # _____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Diagnosis Code ☐ _____ Diagnosis _____ Weight _____
Testing? ☐ Yes ☐ No Results _____
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

☐ **CIMDUO** SIG: One tablet by mouth daily QTY _____ Refills _____
☐ **COMBIVIR** 150/300mg SIG: One tablet by mouth twice daily QTY _____ Refills _____
☐ **DESCOVY** SIG: One tablet by mouth daily QTY _____ Refills _____
EMTRIVA ☐ 200 mg capsule ☐ 10 mg/mL solution
SIG: _____ QTY _____ Refills _____
EPIVIR ☐ 100 mg ☐ 150 mg ☐ 300 mg ☐ 5 mg/mL ☐ 10 mg/mL
SIG: _____ QTY _____ Refills _____
☐ **EPZICOM** SIG: One tablet by mouth daily QTY _____ Refills _____
RETROVIR ☐ 100 mg ☐ 300 mg ☐ 10 mg/mL
SIG: _____ QTY _____ Refills _____
☐ **TRIZIVIR** 300/150/300 mg
SIG: One tablet by mouth twice daily QTY _____ Refills _____
TRUVADA ☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg
SIG: One tablet by mouth daily QTY _____ Refills _____
VIDEX EC ☐ 125 mg ☐ 200 mg ☐ 250 mg ☐ 400 mg
SIG: _____ QTY _____ Refills _____
VIREAD ☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg ☐ 40 mg/gm powder
SIG: _____ QTY _____ Refills _____
ZERIT ☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg ☐ 1 mg/ml
SIG: _____ QTY _____ Refills _____
ZIAGEN ☐ 300 mg ☐ 20 mg/ml
SIG: _____ QTY _____ Refills _____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

☐ **EDURANT** SIG: One tablet by mouth daily w/ normal-high calorie meal QTY _____ Refills _____
INTELENCE ☐ 25 mg ☐ 100 mg ☐ 200 mg
SIG: _____ QTY _____ Refills _____
☐ **RESCRIPTOR**
SIG: Take 400mg by mouth three times a day QTY _____ Refills _____
SUSTIVA ☐ 600 mg tab ☐ 50 mg cap ☐ 200 mg cap
SIG: _____ QTY _____ Refills _____
VIRAMUNE ☐ 200 mg ☐ 50 mg/5ml
SIG: _____ QTY _____ Refills _____
VIRAMUNE XR ☐ 100 mg ☐ 400 mg
SIG: _____ QTY _____ Refills _____

HGH

SEROSTIM ☐ 4 mg ☐ 5mg ☐ 6 mg
SIG: Inject _____mg daily QTY _____ Refills _____

FUSION INHIBITORS

☐ **FUZEON** SIG: _____ QTY _____ Refills _____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS ☐ 250 mg
SIG: _____ QTY _____ Refills _____
CRIXIVAN ☐ 200 mg ☐ 400 mg
SIG: _____ QTY _____ Refills _____
☐ **EVOTAZ** Sig: One tablet by mouth daily with food QTY _____ Refills _____
INVIRASE ☐ 500 mg
SIG: _____ QTY _____ Refills _____
KALETRA ☐ 100 mg/25 mg ☐ 200 mg/50 mg ☐ 80 mg/20 mg/ml solution
SIG: _____ QTY _____ Refills _____
LEXIVA ☐ 700 mg ☐ 50mg/ml
SIG: _____ QTY _____ Refills _____
NORVIR ☐ 100 mg tab ☐ 80 mg/ml solution ☐ 100 mg oral powder
SIG: _____ QTY _____ Refills _____
PREZCOBIX Sig: One tablet by mouth daily with food QTY _____ Refills _____
PREZISTA ☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg ☐ 100 mg/mL susp.
SIG: _____ QTY _____ Refills _____
REYATAZ ☐ 150 mg ☐ 200 mg ☐ 300 mg cap ☐ 50 mg packet
SIG: _____ QTY _____ Refills _____
VIRACEPT ☐ 250 mg ☐ 625 mg
SIG: _____ QTY _____ Refills _____

OTHER MEDICATIONS

☐ **ATRIPLA** SIG: One tab by mouth daily on empty stomach QTY _____ Refills _____
☐ **BIKTARVY** SIG: One tablet by mouth daily QTY _____ Refills _____
☐ **COMPLERA** SIG: One tablet by mouth daily with food QTY _____ Refills _____
☐ **GENVOYA** SIG: One tablet by mouth daily with food QTY _____ Refills _____
ISENTRESS ☐ 100 mg ☐ 25 mg chew ☐ 100 mg chew ☐ 100 mg packet
SIG: _____ QTY _____ Refills _____
☐ **ISENTRESS HD** 600 mg SIG: Two tablets by mouth daily QTY _____ Refills _____
☐ **JULUCA** SIG: One tablet by mouth daily with a meal QTY _____ Refills _____
☐ **ODEFSEY** SIG: One tablet by mouth daily with food QTY _____ Refills _____
☐ **STRIBILD** SIG: One tablet by mouth daily with food QTY _____ Refills _____
☐ **SYMFI** 600/300/300 SIG: 1 tab by mouth on an empty stomach at bedtime QTY _____ Refills _____
☐ **SYMFI LO** 400/300/300 SIG: 1 tab by mouth on an empty stomach at bedtime QTY _____ Refills _____
☐ **TRIUMEQ** SIG: One tablet by mouth daily QTY _____ Refills _____
☐ **TYBOST** 150 mg tab SIG: One tablet by mouth daily QTY _____ Refills _____
TIVICAY ☐ 10 mg ☐ 25 mg ☐ 50 mg
SIG: _____ QTY _____ Refills _____

☐ **OTHER** _____
SIG _____ QTY _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ *Dispense as written* **Date** _____

Prescriber's Signature (signature required. NO STAMPS) _____ *Product Substitution Permitted* **Date** _____