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# HCV/HIV Referral Form

Surescripts ID #:

Office #: 1-210-881-0890

Fax #: 1-210-569-6464

Referral Info

## PATIENT INFORMATION

PATIENT NAME		SSN #:		DOB:	
ADDRESS:		CITY:		STATE:	
HOME PHONE:		CELL PHONE:		ZIP:	
HEIGHT:		WEIGHT:		GENDER: MALE FEMALE	
Email ADDRESS:		DIAGNOSIS CODE:			

## INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

## PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

HEPATITIS C			HIV		
Mavyret, Harvoni, Daklinza, Epclusa, Vosevi, Zepatier, Sovaldi, Ribavirin			Aptivus, Atripla, Biktarvy, Combivir, Complera, Crixivan, Descovy, Edurant, Emtriva, Epivir, Epzicom, Evotaz, Evtriva, Fuzeon, Genvoya, Intelence, Invirase, Isentress, Kaletra, Lamivudine, Lexiva, Norvir, Odefsey, Prezcoibix, Prezista, Rescriptor, Retrovir, Reyataz, Selzentry, Stribid, Sustiva, Tivicay, Triumeg, Trizivir, Truvada, Videx EC, Viracept, Viramune, Viread, Zerit, Ziagen		
<b>Medication:</b>			<b>Medication:</b>		
<b>SIG/DIRECTIONS:</b>			<b>SIG/DIRECTIONS:</b>		
<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>	<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>
<b>Medication:</b>			<b>Medication:</b>		
<b>SIG/DIRECTIONS:</b>			<b>SIG/DIRECTIONS:</b>		
<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>	<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>
<b>Medication:</b>			<b>Medication:</b>		
<b>SIG/DIRECTION:</b>			<b>SIG/DIRECTION:</b>		
<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>	<b>STRENGTH:</b>	<b>QTY:</b>	<b>REFILLS:</b>

## PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact/Faxed by:		Email:	
NPI#:	TAXID#:	Deliver To: <input type="radio"/> Patient <input type="radio"/> MD 1 <sup>ST</sup> Fill Only <input type="radio"/> MD All Orders	
Prescriber Signature:			
<input type="radio"/> Dispense as written	Date		

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

\* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

