Sterling SPECIALTY PHARMACY

Human Immunodeficiency Virus Prescription Referral Form

888.618.4126 • Fax: 866.588.0371 • www.sterlingspecialtyrx.com

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Date Medication Needed: _____ **Ship to:** ☐Patient's Home ☐Prescriber's Office ☐Pharmacy to Coordinate

1 Patient Information

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

Patient Name: _____ Birthdate: _____ Sex: ☐Male ☐Female Height: _____ Weight: _____ ☐lbs. ☐kg.

Primary Phone: _____ Secondary Phone: _____ Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Email: _____ Caregiver Name: _____

2 Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____

3 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs & Tests with the prescription to expedite Prior Authorization.

Date of Diagnosis: _____ ICD-10: _____ Blood Results: Date Drawn: _____ Hgb/Hct: _____ WBC: _____

Contraindications: ☐ No ☐ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1. CD/4/T-cell		
2. HIV RNA		
3. Viral Load		
4. Liver Biopsy		

Injection Training:

☐Pharmacist to Provide ☐Patient Trained in MD Office

☐Manufacturer Nurse Support

If Prior Authorization is Denied:

☐Automatically Draft Appeal for Review

☐Send Preferred Formulary Alternatives

4 Prescription Information

Patient Name: _____ Patient's Date of Birth: _____

Medication				Strength / Directions	Qty.	Refills
NRTIs/NNRTIs						
☐ EDURANT®	☐ RESCRIPTOR®	☐ VIRAMUNE®	☐ ZIAGEN®	Strength _____		
☐ EMTRIVA®	☐ RETROVIR®	☐ VIRAMUNE XR®				
☐ EPIVIR®	☐ SUSTIVA®	☐ VIREAD®		Directions _____		
☐ INTELENCE®	☐ VIDEX®	☐ ZERIT®				
Protease Inhibitors						
☐ APTIVUS®	☐ INVIRASE®	☐ PREZISTA®		Strength _____		
☐ CRIXIVAN®	☐ KALETRA®	☐ REYATAZ®				
☐ EVOTAZ™	☐ LEXIVA®	☐ VIRACEPT®		Directions _____		
☐ NORVIR® Capsules	☐ NORVIR® Tablets					
Combinations						
☐ ATRIPLA®	☐ GENVOYA®	☐ TRIUMEQ®		Strength _____		
☐ COMBIVIR®	☐ ODEFSEY®	☐ TRIZIVIR®				
☐ COMPLERA®	☐ PREZCOBIX®	☐ TRUVADA®		Directions _____		
☐ EPZICOM®	☐ STRIBILD®					
Integrase Inhibitor/CCR5 I						
☐ ISENTRESS®	☐ SELZENTRY®	☐ TIVICAY®	☐ VITEKTA™	Strength _____		
				Directions _____		
Supportive Medications						
☐ Acyclovir	☐ Dapsone	☐ Tybost®	☐ Other	Strength _____		
☐ Bactrim®	☐ Diflucan®	☐ Valtrex®				
☐ Bactrim® DS	☐ Fuzeon®	☐ Zithromax®		Directions _____		

Prescriber Signature: Prescriber, please sign and date below:

Dispense as written: | Date: | Substitution Permissable: | Date:

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services and patient assistance programs.

# of Prescriptions: _____