INFECTIOUS DISEASE
Referral Form

MedicoRx Specialty & HOME INFUSION PHARMACY

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Today's Date: _____ Needs By Date: _____ SHIP TO: ❑ Patient ❑ Office ❑ Other_____

PATIENT INFORMATION		PRESCRIBER INFORMATION	
PATIENT NAME		**PRESCRIBER NAME**	
ADDRESS		**NPI#**	
CITY, STATE, ZIP		**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**	**ADDRESS**	
SOCIAL SECURITY#		**CITY, STATE, ZIP**	
DATE OF BIRTH	❑ **MALE** ❑ **FEMALE**	**PHONE#**	**FAX#**
HEIGHT	**WEIGHT** ❑ **LBS** ❑ **KG**		
ALLERGIES		**CONTACT PERSON**	
OTHER MEDICATIONS			

CLINICAL INFORMATION

Diagnosis: ❑ B20 HIV/AIDS ❑ B18.1 Chronic Hepatitis B ❑ B18.2 Chronic Hepatitis C ❑ Other:_____

CD/4/Ty cell: _____ HIV RNA: _____ HCV genotype: _____ Viral Load: _____ (Copies or IU/ml) ALT _____ Liver Biopsy Results:_____ **BLOOD RESULTSP Date Drawn: Hgb/Hct: WBC:**

PRESCRIPTION INFORMATION

	DIRECTIONS	QUANTITY	REFILLS
NRTIs/NNRTIs			
❑ Edurant			
❑ Emtriva			
❑ Epivir			
❑ Intelence			
❑ Resciptor			
❑ Retrovir			
❑ Sustiva			
❑ Videx			
❑ Viramune			
❑ Viread			
❑ Zenrit			
❑ Ziagen			
PROTEASE INHIBITORS			
❑ Aptivus			
❑ Invirase			
❑ Kaletra			
❑ Lexiva			
❑ Norvir			
❑ Prezista			
❑ Reyataz			
❑ Viracept			

	DIRECTIONS	QUANTITY	REFILLS
COMBINATIONS			
❑ Atripla			
❑ Combivir			
❑ Complera			
❑ Epzicom			
❑ Stribild			
❑ Trizivir			
❑ Truvada			
INTEGRASE INHIBITOR/CCR5 I			
❑ Isentress			
❑ Selzentry			
❑ Tivicay			
OTHER MEDS			

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

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

_____

Prescriber's Signature (no stamps) If Brand required check ❑ DAW_____ Initials_____ Date