



CEDRA

HIV REFERRAL FORM

FAX: 888.889.7129

TOLL FREE: 844.233.7279

CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone: SSN#: Language: English Other Address: Sex: Male Female Height: Weight: lbs kg City: State: Zip: Known Allergies:

\* PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING \*

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#: Address: Phone: E-mail: City: State: Zip: Key Contact: Phone: Fax: STATUS UPDATE PREFERENCE: Phone Text Fax E-mail:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis: ICD-10 Code: Serum Creatinine: Prior Treatment Regimen, Date, Reason For DC: CD4 Count: Viral Load: Date of Labs: Any pertinent genotype or phenotype testing available: Yes (please fax profile) No

PRESCRIPTION INFORMATION

Table with columns: MEDICATION, DOSE/STRENGTH, SIG, QTY., REFILLS, MEDICATION, DOSE/STRENGTH, SIG, QTY., REFILLS. Includes categories like SINGLE TABLET, NNRTIs, Protease Inhibitors, NRTIs, Entry Inhibitors, Integrase Inhibitors, Pharmacokinetic Enhancers, and Other Medications.

Deliver To: Patient Home MD Office Prescriber Signature: (Please sign and date below) Your signature authorizes Cedra 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.

Substitution Permissible Date Dispense as written "DAW" Date

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