CEDRA
PHARMACY

HIV / AIDS

REFERRAL FORM

FAX (888) 842 7574
Toll Free: (844) 233 7279
CEDRAPHARMACY.COM

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office

PATIENT INFORMATION

Patient Name: _____ DOB: _____
SSN#: _____ Preferred Phone: (____) ____-_____
Address: _____
Alternate Caregiver Name: _____

Language: ☐ English ☐ Other _____
Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs. kg
Known Allergies: _____
City: _____ State: _____ Zip: _____
Preferred Phone : (____) ____-_____

PLEASE FAX **FRONT AND **BACK** COPY OF PHARMACY BENEFIT CARD, CLINICAL NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE THE PRIOR AUTHORIZATION**

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ City: _____ State: _____ Zip: _____ Key Contact: _____
Email: _____ Phone: _____ Fax: _____
STATUS UPDATE COMMUNICATION PREFERENCE: ☐ Phone ☐ Text ☐ Fax: ☐ Email: _____

CLINICAL INFORMATION

☐ 042 HIV/AIDS ☐ 070.54 HCV ☐ 070.32 HBV ☐ 799.4 Cachexia
Other: _____
CD4 Count: _____ HIV RNA: _____ WBC: _____ Hgb/Hct: _____ CrCl: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG	QTY	REFILL
NRTIs				
Emtriva				
Epivir				
Retrovir				
Videx EC				
Viread				
Zerit				
Ziagen				
Combination Antiretrovirals				
Atripla				
Combivir				
Complera				
Epzicom				
Stribild				
Triumeq				
Trizivir				
Truvada				
Entry Inhibitors				
Fuzeon				
Selzentry				
OTHER				

MEDICATION	STRENGTH	SIG	QTY	REFILL
NNRTIs				
Edurant				
Intelence				
Rescriptor				
Sustiva				
Viramune				
Protease Inhibitors				
Aptivus				
Crixivan				
Invirase				
Kaletra				
Lexiva				
Prezcobix				
Prezista				
Reyataz				
Viracept				
Pharmacokinetic Enhancers				
Norvir				
Tybost				
Integrase Inhibitors				
Isentress				
Tivicay				
Vitekta				
OTHER				

I authorize any division of Cedra Pharmacy to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program , aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at anytime in writing by sending a letter to Cedra Pharmacy. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy.

Patient Signature (required for participation): _____ Date: _____

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 _____

IMPORTANT NOTICE: This fax is intended to be delivery only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.