HIV
REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (If applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	Referral Contact Email	
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber State License #		DEA #
NPI #		Medicaid UPIN #

INSURANCE INFORMATION

To assist with prior authorization, please provide the following documents where applicable:

☐ Copy of front and back of insurance card ☐ Recent laboratory results ☐ Recent office notes ☐ CCR5/CXCR4 Tropism Assay

CLINICAL INFORMATION

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment		Therapy Start Date
Sample/Starter Product Provided? ☐ Yes ☐ No	If yes, Provide Qty	Date Sample Provided
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Allergies ☐ NKDA ☐ Drug Allergies (please list)	
Has patient been treated previously for this condition? ☐ Yes ☐ No	If yes, medication(s) (please list)	
Is patient currently on therapy? ☐ Yes ☐ No	If yes, medication(s) (please list)	
Other medications patient is currently taking including OTC medications with dosage and directions (medication profile may be faxed)		
Recent CD4 Count Date	Viral Load/HIV RNA Date	
Creatinine Clearance (CrCl)	Hgb/Hct	WBC/ANC

HLA-B*5701
☐ Present ☐ Reactive ☐ N/A

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

ICD-10 Codes

- ☐ B18.0 Chronic Viral Hepatitis B with Delta Agent
- ☐ B18.1 Chronic Viral Hepatitis B without Delta Agent
- ☐ B18.2 Chronic Viral Hepatitis C
- ☐ B20 Human Immunodeficiency Virus Disease (HIV)
- ☐ R64 Cachexia (HIV Wasting)

PrEP/PEP:

- ☐ Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- ☐ Z11.4 Encounter for screening for human immunodeficiency virus
- ☐ Z11.59 Encounter for screening for other viral diseases
- ☐ Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
- ☐ Z20.21 Contact with and (suspected) exposure to potentially hazardous body fluids
- ☐ Z20.5 Contact with and (suspected) exposure to viral hepatitis
- ☐ Z20.6 Contact with and (suspected) exposure to HIV
- ☐ Z71.7 Encounter for HIV counseling
- ☐ Other Code _____
  Description _____

We accept Escribe and fax prescriptions.

P 855.896.9254 | **F** 877.645.7514 | 10004 S. 152nd St, Suite A, Omaha NE 68138

REV.0321

PRESCRIPTIONS

MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)

Patient Last Name	Patient First Name	DOB
Address		
City	State	ZIP
Date of Issue		

Practice / Facility Name		
Practice Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

In order for a brand name product to be dispensed, the prescriber must handwrite “Brand Necessary” or “Brand Medically Necessary,” or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS	DAW (Dispense as Written)
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Total RXs ______

______________________________ ____ /____ /____

Prescriber Signature Date

______________________________ ____ /____ /____

Supervising Physician Signature (where required by state law) Date

The information contained in this document will become a legal prescription.* ***Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*