

Send updates to: Fax: _____ Email: _____ Text: _____

Physician Information

Prescriber Name:				<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:	
Office Contact:			Practice Name / Supervising MD:				
Address:			City:				
State:	Zip:	Phone:	Fax:				

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:		Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N			

Insurance Information

Primary Insurance:		Policy ID:	Group #:	
Policyholder Name:		Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code: <input type="radio"/> B20 <input type="radio"/> B21 <input type="radio"/> B22 <input type="radio"/> B23 <input type="radio"/> B24		<input type="radio"/> HIV/AIDS Cachexia <input type="radio"/> (HIV Wasting)	Date of Diagnosis: / /	Patient Weight:	BMI:
CD4 / TCELL Count:	Viral Load (HIV RNA)	HGB / HCT:	White Blood Cell Count:		
TREATMENT ARRANGEMENTS:	Ship Meds: <input type="radio"/> Home <input type="radio"/> Doctor's Office	PrEP Therapy: <input type="radio"/> Y <input type="radio"/> N			

Prescription Information

	Medication	Dose/Strength	Sig	Qty	Refills		Medication	Dose/Strength	Sig	Qty	Refills
NNRTI'S	<input type="radio"/> EDURANT®					INTEGRASE INHIBITORS	<input type="radio"/> ISENTRESS®				
	<input type="radio"/> INTELENCE®						<input type="radio"/> TIVICAY®				
	<input type="radio"/> SUSTIVA®						<input type="radio"/> EMTRIVA®				
	<input type="radio"/> VIRAMUNE®						<input type="radio"/> EPIVIR®				
COMBO/ARV'S	<input type="radio"/> ATRIPLA®					NRTI'S	<input type="radio"/> RETROVIR®				
	<input type="radio"/> COMBIVIR®						<input type="radio"/> VIDEX®				
	<input type="radio"/> COMPLERA®						<input type="radio"/> VIREAD®				
	<input type="radio"/> DESCOVY®						<input type="radio"/> ZERIT®				
	<input type="radio"/> EPZICOM®						<input type="radio"/> ZIAGEN®				
	<input type="radio"/> EVOTAZ®						PROTEASE INHIBITORS	<input type="radio"/> CRIXIVAN®			
	<input type="radio"/> GENVOYA®					<input type="radio"/> INVIRASE®					
	<input type="radio"/> ODEFSEY®					<input type="radio"/> KALETRA®					
	<input type="radio"/> PREZOBIX®					<input type="radio"/> LEXIVA®					
	<input type="radio"/> STRIBILD®					<input type="radio"/> NORVIR®					
	<input type="radio"/> TRIUMEQ®					<input type="radio"/> PREZISTA®					
	<input type="radio"/> TRIZIVIR®					<input type="radio"/> REYATAZ®					
	<input type="radio"/> TRUVADA®					<input type="radio"/> VIRACEPT®					
	ENTRY INHIBITORS										
<input type="radio"/> FUZEON®						<input type="radio"/> SELZENTRY®					

Additional Instructions

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

Physician Signature: _____	Date _____	Physician Signature: _____	Date _____
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