



Patient Referral/Medication Request – HIV/AIDS

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866 FAX-ASRX)

Today's Date:

Anticipated Start Date:

PATIENT INFORMATION

First Name:		Last Name:			
Address:		City:		State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:	
DOB:	Height:	Weight:	Email Address:		
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Allergies:			

INSURANCE INFORMATION

Primary Insurance:			Pharmacy Benefit Manager (PBM):		
Policy #:	Group #:	Insured:	Phone:		
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:		
Secondary Insurance:					
Policy #:	Group #:	Insured:	Phone:		

PHYSICIAN INFORMATION

First Name:		Last Name:			Circle one: M.D. D.O. N.P. P.A.
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:			Email Address:		Phone:

DIAGNOSIS CLINICAL INFORMATION

042 HIV/AIDS Other _____ CD4 Count: _____ Viral Load: _____ Date: _____

PRESCRIPTION (Please select from below and provide approximate days supply.) P = preferred PG = preferred generic only (brand medical exception)

MEDICATION	STRENGTH	DIRECTION	QTY	REFILL
COMBINATION Antiretrovirals				
<input type="checkbox"/> Atripla				
P <input type="checkbox"/> Combivir				
<input type="checkbox"/> Complera				
<input type="checkbox"/> Epzicom				
<input type="checkbox"/> Trizivir				
P <input type="checkbox"/> Truvada				
NRTIs/NNRTIs				
<input type="checkbox"/> Edurant				
P <input type="checkbox"/> Emtriva				
P <input type="checkbox"/> EpiVir				
<input type="checkbox"/> Intelence				
<input type="checkbox"/> Rescriptor				
PG <input type="checkbox"/> Retrovir (zidovudine)				
P <input type="checkbox"/> Sustiva				
PG <input type="checkbox"/> Videx EC (didanosine EC)				
P <input type="checkbox"/> Viramune				
P <input type="checkbox"/> Viread				
PG <input type="checkbox"/> Zerit (stavudine)				
P <input type="checkbox"/> Ziagen				
PROTEASE INHIBITORS				
<input type="checkbox"/> Aptivus				
P <input type="checkbox"/> Crixivan				
P <input type="checkbox"/> Invirase				
P <input type="checkbox"/> Kaletra				
P <input type="checkbox"/> Lexiva				
P <input type="checkbox"/> Norvir Soft Gell Cap				
P <input type="checkbox"/> Norvir Tablet				
<input type="checkbox"/> Prezista				
P <input type="checkbox"/> Reyataz				
P <input type="checkbox"/> Viracept				
INTEGRASE INHIBITORS				
<input type="checkbox"/> Isentress				
ENTRY INHIBITORS				
<input type="checkbox"/> Selzentry				
FUSION INHIBITORS				
<input type="checkbox"/> Fuzeon				
GROWTH HORMONES				
<input type="checkbox"/> Egrifta				
<input type="checkbox"/> Serostim				
OTHER MEDS				
<input type="checkbox"/>				

Prescriber's Signature (Required by Law): _____ Date: ____/____/____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____