HIV
Prescription Referral Form

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

blue sky SPECIALTY PHARMACY

PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: ______ Last Name: ______ Date of Birth: ______ ☐ M ☐ F

Street Address: ______ City: ______ State: ______ Zip: ______

Cell Phone: ______ SSN: ______ Patient Preferred Language: ☐ English ☐ Spanish ☐ ______

PRESCRIBER INFORMATION

Name: ______ DEA: ______ NPI: ______

Address: ______

Phone Number: ______ Fax Number: ______ Contact Person: ______

Office's Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Portal ☐ Email: ______ ☐ Other: ______

PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: ☐ HIV1 ☐ HIV2 ☐ ______ ICD 10: ______ Weight: ______ Height: ______

Opportunistic Infection: ☐ No ☐ Yes ______ Treated: ☐ No ☐ Yes ______

Treatment Naive: ☐ No ☐ Yes ______ Viral Load: ______ CD4 Count: ______ HEP B: ☐ No ☐ Yes

HLA-B5701 Status: ☐ Positive ☐ Negative Known Resistance or Genetic Mutations: ☐ No ☐ Yes ______

Previous / Failed Medication: ______

MEDICATION [PLEASE NOTE - THIS IS NOT AN INCLUSIVE LIST, PLEASE WRITE IN DESIRED MEDICATIONS ON THE BOTTOM OF THE FORM]

SINGLE TABLET REGIMENS

☐ BIKTARVY ☐ COMPLERA ☐ DELSTRIGO ☐ DOVATO ☐ GENVOYA

☐ JULUCA ☐ ODEFSEY ☐ STRIBILD ☐ SYMTUZA ☐ TRIUMEQ

SIG	QTY	RFLS
☐ Take 1 tablet by mouth once daily	30	

INJECTION

CABENUVA FUZEON

COMBO TABLET REGIMEN

DESCOVY TRUVADA

SINGLE INGREDIENT TABLETS

EDURANT LEXIVA PIFELTRO PREZCOBIX PREZISTA

RUKOBIA SELZENTRY TIVICAY ISENTRESS ISENTRESS HD

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver Medication to Patient ☐ Deliver Medication to MDO for First Fill

MEDICATION	STREGTH	ROA (PO / IV / SC)	SIG	QTY	RFLS

PRESCRIPTION SIGNATURE

Dispense as Written: ______ Substitution Permitted: ______ Date: ______

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.