KERR HEALTH
Specialty Pharmacy

HIV/AIDS Referral Form

Phone (866) 443-1904 • Fax (877) 465-6091 • www.kerrhealth.com

TODAY'S DATE:
DATE SHIPMENT NEEDED:
❏ **NEW START** ❏ **CONTINUATION OF THERAPY**
SHIP TO: ❏ PATIENT ❏ PHYSICIAN ❏ KERR DRUG STORE: ________________

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME):		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	❏ MALE ❏ FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
CAN PHARMACY LEAVE A VOICEMAIL? ❏ YES ❏ NO	VOICEMAIL PHONE #:		
PHYSICIAN NAME:		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

PRESCRIPTION INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
SECONDARY INSURANCE:	ID#:	GROUP#:	PHONE#:

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: ❏ HIV ❏ AIDS CD4 COUNT: __________ VIRAL LOAD: (PLEASE INCLUDE A COPY OF THE MOST RECENT LABS) ________

HAS PATIENT FAILED ANY PREVIOUS THERAPIES?	❏ YES	❏ NO	FAILED MEDICATIONS:
IS THERE LAB EVIDENCE OF RESISTANCE?	❏ YES	❏ NO	RESISTANT MEDICATIONS:
IS PATIENT CURRENTLY ON THERAPY?	❏ YES	❏ NO	CURRENT MEDICATIONS:

PRESCRIPTION INFORMATION

Please enter or affix prescription here or attach as additional page(s) to fax

If you would like brand name, please write "Brand Medically Necessary". Please note that Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.

Rx

Physician Signature: ______________________________ Date: ______________

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