APEX SPECIALTY PHARMACY

HIV

Benefit Investigation + Prior Authorization Support

Date _____
Ship to:: ☐ Patient ☐ Provider
☐ Benefits Investigation Only
☐ Injection Training Requested

PATIENT INFORMATION::			
Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS

☐ ICD-10 _____ **Diagnosis Description** _____

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION::

ALLERGIES / SENSITIVITIES::

PRESCRIPTION INFORMATION::				
Medication	Dosage	Dosing Instructions	Qty	Refills

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN