APEX SPECIALTY SOLUTIONS

Fax: 866.680.3539 | Phone: 855.257.2584 (toll free)

Benefit Investigation +
Prior Authorization Support

HIV

DATE _____ / _____ / _____ SHIP TO ☐ Patient ☐ Dr. Office

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:	

INSURANCE PROVIDER (*Enter information here OR send Insurance Card/Demographic Page*)

Ins. Co: ID: Group: Ins. Phone:

DIAGNOSIS ***PLEASE INCLUDE MOST RECENT CHART NOTES AND LABS***

☐ ICD-9: _____ Diagnosis Description: ____

PREVIOUS THERAPIES FOR THIS CONDITION W/ DURATION

Med:		How Long?	
Med:		How Long?	

ALLERGIES/SENSITIVITIES

PRESCRIPTION INFORMATION

☐ *Check if you want ONLY a Benefits Investigation Report* ☐ *Injection training requested*

Medicine	Dosage	Dosing Instructions	Qty	Refills
			#	Refill: _____
			#	Refill: _____
			#	Refill: _____

Prescriber Signature ____________________________ ____________________________ Date: ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN