NON-FORMULARY ANTIRETROVIRAL (ARV) REQUEST FORM

Please Fax Completed Form to HealthPAC HIV at 510-567-6850
TELEPHONE: 510-383-1790

PATIENT INFORMATION:

LAST NAME FIRST NAME

____

Patient's One-e-App ID# Date of Birth

____

Most Recent Viral Load test/date:______________________

Most Recent CD4 Count/date:__________________________

ARV History
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PHARMACY INFORMATION:

Pharmacy Name NABP#

____

Phone Number Fax Number

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PHYSICIAN INFORMATION:

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Last Name First Name

____

Phone Number Fax Number

____

DEA Number E-Mail address

____

Signature of pharmacist or physician Date

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ARV DRUG(S) REQUESTED (HealthPAC HIV Non-formulary ARV(s) only):

GENERIC NAME	DIRECTIONS	QUANTITY

REQUEST: † APPROVED AS REQUESTED † / APPROVED AS MODIFIED / †DENIED
COMMENTS:

ALAMEDA HEALTHPAC HIV RX USE ONLY
AUTHORIZATION VALID FROM: ____/____/_____ TO ___/____/_____ BY:_________DATE:_____________ †LONG TERM AUTHORIZATION †PRIOR AUTHORIZATION REQUIRED FOR EACH FILL NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S HEALTHPAC HIV PROGRAM ELIGIBILITY. BE SURE PATIENT'S ELIGIBILITY IS CURRENT BEFORE DISPENSING DRUG.