HIV REFERRAL FORM

Updated August 2020

Patient Name ______________________ Today's Date__________ ☐ *NEW* Patient ☐ *CURRENT* Patient
DOB ___________ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language __________
Best Phone ________________ Email ___________________________
Street Address ______________________ Apt#_____ City ______________ State _____ Zip ______
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address ______________
Allergies ____
Current Medications including OTC's (*please fax a complete list*) ______________________

Please Fax Insurance Card(s) both sides

Insured's Name ________________________
Relation to Patient ________________________
Primary Insurance ________________________
ID# ______________ Group # ______________
Secondary Insurance ________________________
ID# ______________ Group # ______________

Ordering Prescriber ________________________
Office Contact ________________________
Street Address ________________________ Suite #_____
City ______________ State _____ Zip ________
Tel ______________ Fax ______________
Email ________________________
License# ________________________
NPI# ________________________

ICD-10 Code ☐ **B20** HIV ☐ **B18.2** HCV (chronic) ☐ **B18.1** HBV (chronic) ☐ **R64** Cachexia
☐ Other ______________ Diagnosis ________________________
☐ **Yes (naïve)** ☐ **No** Is Patient treatment naïve? If No, what drugs ______________ # of Weeks _____
CD4/T-Cell Count ______ HIV RNA Count ______ Hgb/Hct ______ ANA ______ WBC ______ Creatine Clearance ______

PRESCRIPTION

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

☐ **COMBIVIR** 150/300mg
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **DESCOVY** 200/25mg
Tabs #_____ Refill _____ Sig ____________
☐ **EMTRIVA** 200mg
Caps #_____ Refill _____ Sig ____________
☐ **EPIVIR** 150mg 300mg 10mg/ml
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **EPZICOM** 600/300mg
Tabs #_____ Refill _____ Sig ____________
☐ **RETROVIR** 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **TRIZIVIR** 300/150/300mg
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **TRUVADA** 200/300mg
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **VIDEX EC** 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd #_____ Refill _____ Sig ____________
☐ **VIREAD** 300mg
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **ZERIT** 15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol #_____ Refill _____ Sig ____________
☐ **ZIAGEN** 300mg Oral Sol. 20mg/ml
Tabs | Sol #_____ Refill _____ Sig ____________

FUSION INHIBITORS

☐ **FUZEON** 90mg
Refill _____ Sig ____________
☐ **SELZENTRY** 150/300
Tabs #_____ Refill _____ Sig ____________

☐ OTHER MEDICATION ____________

Tabs #_____ Refill _____ Sig ____________

☐ ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

PROTEASE INHIBITOR ANTIRETROVIRAL

☐ **APTIVUS** 250mg Oral Susp. 100mg/ml
Caps #_____ Refill _____ Sig ____________
☐ **CRIXIVAN** 200mg 333mg 400mg
Caps #_____ Refill _____ Sig ____________
☐ **EVOTAZ** 300mg 150mg
Tabs #_____ Refill _____ Sig ____________
☐ **INVIRASE** 200mg 500mg
Caps | Sol #_____ Refill _____ Sig ____________
☐ **KALETRA** 100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **LEXIVA** 700mg Oral Susp. 50mg/ml
Tabs #_____ Refill _____ Sig ____________
☐ **NORVIR** 100mg 80mg/ml
Caps | Sol #_____ Refill _____ Sig ____________
☐ **PREZCOBIX** 800mg 150mg
Tabs #_____ Refill _____ Sig ____________
☐ **PREZISTA** 75mg 150mg 400mg 600mg
Tabs | Sol #_____ Refill _____ Sig ____________
☐ **REYATAZ** 100mg 150mg 200mg 300mg
Caps #_____ Refill _____ Sig ____________
☐ **VIRACEPT** 250mg 625mg
Tabs | Pwd #_____ Refill _____ Sig ____________

HGH

SEROSTIM ☐ 4mg ☐ 5mg ☐ 6mg
Refill _____ Sig ____________

OTHER MEDICATIONS

☐ **ATRIPLA**
Tabs #____ Refill _____ Sig ____________
☐ **BIKTARVY**
Tabs #____ Refill _____ Sig ____________
☐ **CIMDUO**
Tabs #____ Refill _____ Sig ____________
☐ **COMPLERA**
Tabs #____ Refill _____ Sig ____________
☐ **DOVATO**
Tabs #____ Refill _____ Sig ____________
☐ **DELSTRIGO** 100/300/300 mg (*adult dose*)
Tabs #____ Refill _____
Sig: One tab by PO once daily w/ or w/o food
☐ w/ Rifabutin: Take one tab of **DELSTRIGO** 1x daily, then one tab of **PIFELTRO** 100 mg about 12 hrs later
☐ **ISENTRESS** 400 mg
Tabs #____ Refill _____ Sig ____________
☐ **ODEFSEY**
Tabs #____ Refill _____ Sig ____________
☐ **RUKOBIA** 600mg XR tablet
Sig: Take 1 tablet twice daily with or without food
Tabs #____ Refill _____
☐ **STRIBILD**
Tabs #____ Refill _____ Sig ____________
☐ **SYMTUZA** 800/150/200/10mg
Tabs #____ Refill _____ Sig ____________

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

☐ **EDURANT** 25mg — Tabs #_____ Refill _____ Sig ____________
☐ **PIFELTRO** 100 mg tablet (adult dose)
Sig: One tablet orally 1x daily with or without food — Tabs #_____ Refill _____
☐ w/ rifabutin — Sig: one tab taken 2x daily (about 12 hrs apart) — Tabs #_____ Refill _____
☐ **INTELENCE** 100 mg 200mg — Tabs #_____ Refill _____ Sig ____________
☐ **RESCRIPTOR** 200mg — Caps #_____ Refill _____ Sig ____________
☐ **SUSTIVA** 50mg 200mg 600mg — Tabs | Caps #_____ Refill _____ Sig ____________
☐ **VIRAMUNE** 200mg 50mg/5ml — Tabs | Sol #_____ Refill _____ Sig ____________

Prescriber's Signature (signature required. NO STAMPS)______________________ **Date** __________

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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 are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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