

# HIV REFERRAL FORM

Updated July 2019

**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 \_\_\_\_\_  
 **DESCOVI** 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 \_\_\_\_\_

### PROTEASE INHIBITOR ANTIRETROVIRAL

**APTIVUS** 250mg Oral Susp. 100mg/ml  
 Caps # \_\_\_\_\_ Refill \_\_\_\_\_ Sig \_\_\_\_\_  
 **CRIVAN** 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 \_\_\_\_\_

### 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 \_\_\_\_\_  
 **STRIBILD**  
 Tabs # \_\_\_\_\_ Refill \_\_\_\_\_ Sig \_\_\_\_\_  
 **SYM TUZA** 800/150/200/10mg  
 Tabs # \_\_\_\_\_ Refill \_\_\_\_\_ Sig \_\_\_\_\_

### FUSION INHIBITORS

**FUZEON** 90mg  
 Refill \_\_\_\_\_ Sig \_\_\_\_\_  
 **SELZENTRY** 150/300  
 Tabs # \_\_\_\_\_ Refill \_\_\_\_\_ Sig \_\_\_\_\_

### OTHER MEDICATION

Tabs # \_\_\_\_\_ Refill \_\_\_\_\_ Sig \_\_\_\_\_

**HGH SEROSTIM**  4mg  5mg  6mg  
 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 \_\_\_\_\_

### ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

**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.