

HIV Referral Form



Prescriber's Name: _____

DEA #: _____ NPI: _____

Address: _____

Date: _____

Needs by Date: _____

City, State, Zip: _____

Language: _____ Nursing Instruction Required

Phone: _____ Fax: _____

Ship to: Patient MD Office Other: _____

Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet.

Patient Name: _____ Date of Birth: ____/____/____ Gender: M F

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization.**

Diagnosis: B20 HIV B18.2 Chronic HCV B18.1 Hepatitis B R64 Cachexia Other: _____

Date of Diagnosis: _____ Weight: _____ lbs Height: _____ BMI: _____

Prior Failed Medications: _____ Treatment-naive

Concomitant Medications: _____

Allergies/Comments: _____

Lab Data:	Lab Value	Baseline	Current
HIV RNA	_____	_____	_____
CD4/T-cell Count	_____	_____	_____
Hgb/Hct	_____	_____	_____
White Blood Cell Count	_____	_____	_____

PRESCRIPTION INFORMATION

Medication	Strength (mg)	Directions	QTY	Refill	Medication	Strength (mg)	Directions	QTY	Refill
Multi-Combination Antiretrovirals (Fixed Dose)					NRTIs (Nucleoside reverse Transcriptase Inhibitors)				
<input type="checkbox"/> Complera	300/200/25 mg				<input type="checkbox"/> Emtriva	200 mg			
<input type="checkbox"/> Stribild	150/150/200/300 mg				<input type="checkbox"/> Epivir	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Atripla	200/300/600 mg				<input type="checkbox"/> Retrovir	<input type="checkbox"/> 100 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Combivir	150/300 mg				<input type="checkbox"/> Videx Ec	<input type="checkbox"/> 125 <input type="checkbox"/> 200 <input type="checkbox"/> 250 mg <input type="checkbox"/> 400 mg			
<input type="checkbox"/> Descovy	200/ 25 mg				<input type="checkbox"/> Viread	300 mg			
<input type="checkbox"/> Epzicom	300/600 mg				<input type="checkbox"/> Zerit	<input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 40 mg			
<input type="checkbox"/> Evtaz	300/150 mg				<input type="checkbox"/> Ziagen	300 mg			
<input type="checkbox"/> Genvoya	150/150/200/10				NNRTIs (Non-Nucleoside Reverse Transcriptase Inhibitors)				
<input type="checkbox"/> Triumeq	50/300/600 mg				<input type="checkbox"/> Edurant	25 mg			
<input type="checkbox"/> Trizivir	300/150/300 mg				<input type="checkbox"/> Intelence	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg			
<input type="checkbox"/> Truvada	200/300 mg				<input type="checkbox"/> Rescriptor	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg			
<input type="checkbox"/> Prezcobix	800/150 mg				<input type="checkbox"/> Sustiva	600 mg			
Protease Inhibitors					<input type="checkbox"/> Viramune	200 mg			
<input type="checkbox"/> Aptivus	250 mg				<input type="checkbox"/> Viramune XR	400 mg			
<input type="checkbox"/> Crixivan	400 mg				CCR5 Co-Receptor Antagonist				
<input type="checkbox"/> Invirase	500 mg				<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Kaletra	<input type="checkbox"/> 100/25 mg <input type="checkbox"/> 200/50 mg <input type="checkbox"/> 80 /20 mg per ml				Ancillary Medications				
<input type="checkbox"/> Lexiva	700 mg				<input type="checkbox"/> Acyclovir	<input type="checkbox"/> 200 mg <input type="checkbox"/> 400 mg <input type="checkbox"/> 800 mg			
<input type="checkbox"/> Prezista	<input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg				<input type="checkbox"/> Azithromycin	600 mg			
<input type="checkbox"/> Reyataz	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg				<input type="checkbox"/> Bactrim	<input type="checkbox"/> 400/80 mg <input type="checkbox"/> 800/160 mg			
<input type="checkbox"/> Viracept	<input type="checkbox"/> 250 mg <input type="checkbox"/> 625 mg				<input type="checkbox"/> Dapsone	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg			
Pharmacokinetic Enhancers					<input type="checkbox"/> Diflucan	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg			
<input type="checkbox"/> Norvir	100 mg				<input type="checkbox"/> Isoniazid	<input type="checkbox"/> 100 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Tybost	150 mg				<input type="checkbox"/> Mepron	750 mg/5 mL			
Integrase Inhibitors					<input type="checkbox"/> Neupogen	SC/IV			
<input type="checkbox"/> Isentress	400 mg				<input type="checkbox"/> Procrit	SC/IV			
<input type="checkbox"/> Tivicay	50 mg				<input type="checkbox"/> Valtrex	<input type="checkbox"/> 500 mg <input type="checkbox"/> 1000 mg			
<input type="checkbox"/> Vitekta	<input type="checkbox"/> 85 mg <input type="checkbox"/> 150 mg				<input type="checkbox"/> Vitamin B6	50 mg			
Other:					<input type="checkbox"/> Difidid	200 mg			

QUALITY SPECIALTY PHARMACY

*Prescription is VOID if the Number of drugs prescribed is NOT noted. _____ 1 2 3

Physician Signature: _____

Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.