

HIV Referral Form

Date: _____

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363

Phone: 1-844-800-5377

**PATIENT INFORMATION:**
 Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Cell Phone: _____ Home Phone: _____
 Date of Birth: _____ Language: _____
 Caregiver Name & Number: _____
 Gender: Male Female Weight: _____ Height: _____
PRESCRIBER INFORMATION:
 Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA: _____ NPI: _____
 Office Contact: _____
INSURANCE INFORMATION
 Attach a copy of the Front and Back of the Insurance and Prescription Card. Prior Authorization Reference Number: _____
CLINICAL INFORMATION
 ICD10 code: _____
 Comorbidities: _____
 Therapy New Restart Allergies: _____
 Labs: CD4: _____ RNA: _____ Hgb/Hct: _____ WBC/ANC: _____ CrCl: _____
 Medication List: _____
PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refills	Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Aptivus	250mg				<input type="checkbox"/> Reyataz	<input type="checkbox"/> 150 <input type="checkbox"/> 200 <input type="checkbox"/> 300mg			
<input type="checkbox"/> Atripla	600/200/300mg				<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Biktarvy	50/200/25mg				<input type="checkbox"/> Stribid	150/150/200/300mg			
<input type="checkbox"/> Combivir	150/300mg				<input type="checkbox"/> Sustiva	600mg			
<input type="checkbox"/> Complera	200/25/300mg				<input type="checkbox"/> Tivicay	50mg			
<input type="checkbox"/> Crixivan	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg				<input type="checkbox"/> Triumeq	50/300/600mg			
<input type="checkbox"/> Descovy	200mg/25mg				<input type="checkbox"/> Trivicax				
<input type="checkbox"/> Edurant	25mg				<input type="checkbox"/> Trizivir	300/150/300mg			
<input type="checkbox"/> Emtriva	200mg				<input type="checkbox"/> Truvada	200/300mg			
<input type="checkbox"/> Epivir	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg				<input type="checkbox"/> Tybost	150mg			
<input type="checkbox"/> Epzicom	600/300mg				<input type="checkbox"/> Videx EC	<input type="checkbox"/> 125mg <input type="checkbox"/> 200mg <input type="checkbox"/> 250mg <input type="checkbox"/> 400mg			
<input type="checkbox"/> Evotaz	300/150mg				<input type="checkbox"/> Viracept	<input type="checkbox"/> 250mg <input type="checkbox"/> 625mg			
<input type="checkbox"/> Fuzeon	90mg				<input type="checkbox"/> Viramune	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg XR			
<input type="checkbox"/> Genvoya	150/150/1200/10mg				<input type="checkbox"/> Viread	300mg			
<input type="checkbox"/> Intelence	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg				<input type="checkbox"/> Vitekta	<input type="checkbox"/> 85mg <input type="checkbox"/> 150mg			
<input type="checkbox"/> Invirase	<input type="checkbox"/> 200mg <input type="checkbox"/> 500mg				<input type="checkbox"/> Zerit	<input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40mg			
<input type="checkbox"/> Isentress	400mg				<input type="checkbox"/> Ziagen	300mg			
<input type="checkbox"/> Juluca	50mg/25mg				Other Medications				
<input type="checkbox"/> Kaletra	<input type="checkbox"/> 100/25 <input type="checkbox"/> 200/50mg <input type="checkbox"/> 80/20mg/ml				<input type="checkbox"/> Acyclovir	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg <input type="checkbox"/> 800mg			
<input type="checkbox"/> Lexiva	<input type="checkbox"/> 700mg <input type="checkbox"/> 1400mg				<input type="checkbox"/> Bactrim	<input type="checkbox"/> 400/80 <input type="checkbox"/> 800/160mg			
<input type="checkbox"/> Norvir	100mg <input type="checkbox"/> cap <input type="checkbox"/> tab				<input type="checkbox"/> Dapsone	<input type="checkbox"/> 25mg <input type="checkbox"/> 100mg			
<input type="checkbox"/> Odefsey	200/25/25mg				<input type="checkbox"/> Diflucan	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg			
<input type="checkbox"/> Prezobix	800/150mg				<input type="checkbox"/> Isoniazid	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Prezista	<input type="checkbox"/> 600mg <input type="checkbox"/> 800mg				<input type="checkbox"/> Valtrex	<input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg			
<input type="checkbox"/> Rescriptor	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg				<input type="checkbox"/> Zithromax	600mg			
<input type="checkbox"/> Retrovir	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg				<input type="checkbox"/>				

 Ship to: Patient Office Address: _____ Need by Date: _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

 Product substitution permitted Dispense as written *Stamp signature not allowed, physician signature required* Verbal Readback Yes No