Date:__________________

HIV Referral Form

PATIENT INFORMATION:	PRESCRIBER INFORMATION:
Patient Name:________________	Prescriber Name: ________________
Address: ________________	Address: ________________
City, State, Zip:________________	City, State, Zip: ________________
Cell Phone: ____________ Home Phone: ____________	Phone: ________________
Date of Birth:____________ Language:____________	Fax: ________________
Caregiver Name & Number:________________	DEA:____________ NPI: ____________
Gender: ☐ Male ☐ Female Weight: ________ Height: ________	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
☐ **Aptivus**	250mg				☐ **Reyataz**	☐ 150 ☐ 200 ☐ 300mg			
☐ **Atripla**	600/200/300mg				☐ **Selzentry**	☐ 150mg ☐ 300mg			
☐ **Biktarvy**	50/200/25mg				☐ **Stribid**	150/150/200/300mg			
☐ **Combivir**	150/300mg				☐ **Sustiva**	600mg			
☐ **Complera**	200/25/300mg				☐ **Tivicay**	50mg			
☐ **Crixivan**	☐200mg ☐400mg				☐ **Triumeq**	50/300/600mg			
☐ **Descovy**	200mg/25mg				☐ **Trivicax**				
☐ **Edurant**	25mg				☐ **Trizivir**	300/150/300mg			
☐ **Emtriva**	200mg				☐ **Truvada**	200/300mg			
☐ **Epivir**	☐ 150mg ☐ 300mg				☐ **Tybost**	150mg			
☐ **Epzicom**	600/300mg				☐ **Videx EC**	☐ 125mg ☐ 200mg ☐ 250mg ☐ 400mg			
☐ **Evotaz**	300/150mg				☐ **Viracept**	☐ 250mg ☐ 625mg			
☐ **Fuzeon**	90mg				☐ **Viramune**	☐ 200mg ☐ 400mg XR			
☐ **Genvoya**	150/1501200/10mg				☐ **Viread**	300mg			
☐ **Intelence**	☐ 100mg ☐ 200mg				☐ **Vitekta**	☐ 85mg ☐ 150mg			
☐ **Invirase**	☐ 200mg ☐ 500mg				☐ **Zerit**	☐ 15 ☐ 20 ☐ 30 ☐ 40mg			
☐ **Isentress**	400mg				☐ **Ziagen**	300mg			
☐ **Juluca**	50mg/25mg				Other Medications				
☐ **Kaletra**	☐ 100/25 ☐ 200/50mg ☐ 80/20mg/ml				☐ **Acyclovir**	☐200mg ☐ 400mg ☐ 800mg			
☐ **Lexiva**	☐ 700mg ☐ 1400mg				☐ **Bactrim**	☐400/80 ☐ 800/160mg			
☐ **Norvir**	100mg ☐ cap ☐ tab				☐ **Dapsone**	☐25mg ☐ 100mg			
☐ **Odefsey**	200/25/25mg				☐ **Diflucan**	☐ 100mg ☐ 200mg			
☐ **Prezcobix**	800/150mg				☐ **Isoniazid**	☐ 100mg ☐ 300mg			
☐ **Prezista**	☐ 600mg ☐ 800mg				☐ **Valtrex**	☐ 500mg ☐ 1000mg			
☐ **Rescriptor**	☐ 100mg ☐ 200mg				☐ **Zithromax**	600mg			
☐ **Retrovir**	☐ 100mg ☐ 300mg				☐				

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