

Phone: 800.511.5144 • Fax: 877.541.1503

**HIV REFERRAL FORM**

PATIENT INFORMATION				
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:		
Address:		City:	State:	Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information	
PRESCRIBER INFORMATION				
Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT				
<b>Primary Diagnosis:</b> <input type="checkbox"/> B20 HIV / AIDS <input type="checkbox"/> R64 Cachexia (HIV Wasting) <input type="checkbox"/> B18.2 Hepatitis C (chronic) <input type="checkbox"/> B18.1 Hepatitis B <input type="checkbox"/> HIV-infected patients with abdominal lipodystrophy <input type="checkbox"/> Other: _____				
CD4 count: _____, Viral Load/HIV RNA: _____, Hgb/Hct: _____, WBC/ANC: _____, CrCl: _____ (Please include copy of most recent labs)				
<input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ <input type="checkbox"/> Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ <input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ <input type="checkbox"/> How long should patient wait before starting the new medication? _____ <input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____				
PRESCRIPTION INFORMATION				
Medication	Strength	Directions	QTY	Refills
<b>NRTIs</b>				
<input type="checkbox"/> Emtriva	200 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Efavir	<input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Ziagen	<input type="checkbox"/> 300 mg <input type="checkbox"/> 4800 mg/240 mL		QTY: _____	Refills: _____
<b>NNRTIs</b>				
<input type="checkbox"/> Efavir	25 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Intelence	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Pifeltro	100 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Sustiva	<input type="checkbox"/> 200 mg <input type="checkbox"/> 600 mg		QTY: _____	Refills: _____
<b>Combination Antiretrovirals</b>				
<input type="checkbox"/> Atripla	600 mg/200 mg/300 mg	1 tab po daily on empty stomach (CrCl >50 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Biktarvy	50 mg/200 mg/25 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Complera	200 mg/25 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Delstrigo	100 mg/300 mg/300 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Dovato	50 mg/300 mg	1 tab po daily (CrCl > 50 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Epzicom	600 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Genvoya	150 mg/150 mg/200 mg/10 mg	1 tab po daily (CrCl >30 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Juluca	50 mg/25 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Odefsey	25 mg/200 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Stribild	150 mg/150 mg/200 mg/300 mg	1 tab po daily (CrCl >70 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Symfi	600 mg/300 mg/300 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Symfi Lo	400 mg/300 mg/300 mg	1 tab po daily (preferably at bedtime)	QTY: 30	Refills: _____
<input type="checkbox"/> Symtuza	800 mg/150 mg/200 mg/10 mg	1 tab po daily	QTY: 30	Refills: _____
<input type="checkbox"/> Triumeq	600 mg/50 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills: _____
<input type="checkbox"/> Truvada	200 mg/300 mg	<input type="checkbox"/> 1 tab po daily (CrCl >50 mL/min) <input type="checkbox"/> 1 tab po every 48 hours (CrCl 30-49 mL/min)	QTY: 30 QTY: 15	Refills: _____ Refills: _____
<b>Pharmacokinetic Enhancer</b>				
<input type="checkbox"/> Norvir	100 mg	<input type="checkbox"/> 1 tab po daily with food <input type="checkbox"/> 2 tab po daily with food	QTY: 30 QTY: 60	Refills: _____ Refills: _____
<input type="checkbox"/> Tybost	150 mg	1 tab po daily with food	QTY: 30	Refills: _____

**Prescriber's Signature:** \_\_\_\_\_  DAW (Dispense as Written) **Date:** \_\_\_\_\_

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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Date Shipment Needed: \_\_\_\_\_ Ship To:  Patient  Prescriber

Nursing needed;  Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

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PATIENT INFORMATION				
Patient Name: _____				DOB: _____
INSURANCE INFORMATION				
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)				
COPAY CARD ENROLLMENT				
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____		
PRESCRIPTION INFORMATION				
Medication	Strength	Direction	QTY	Refills
<b>Integrase Inhibitors/CCR5 Inhibitors</b>				
<input type="checkbox"/> Isentress	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Isentress HD	600 mg	2 tabs po daily	QTY: 60	Refills: _____
<input type="checkbox"/> Tivicay	<input type="checkbox"/> 50 mg		QTY: _____	Refills: _____
<b>Fusion Inhibitors</b>				
<input type="checkbox"/> Fuzeon	90 mg	90 mg sq twice daily (CrCl > 35 mL/min)	QTY: _____	Refills: _____
<b>Protease Inhibitors</b>				
<input type="checkbox"/> Prezista	<input type="checkbox"/> 150 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> 800 mg <input type="checkbox"/> 100 mg/mL		QTY: _____	Refills: _____
<input type="checkbox"/> Reyataz	<input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg		QTY: _____	Refills: _____
<b>Boosted Protease Inhibitors</b>				
<input type="checkbox"/> Evotaz	300 mg/150 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Prezcoibix	800 mg/150 mg		QTY: _____	Refills: _____
<b>Fusion/Attachment Inhibitors (Others)</b>				
<input type="checkbox"/> Rukobia	600 mg	1 tab po twice daily	QTY: 30	Refills: _____
<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg	2 tab po twice daily	QTY: 120	Refills: _____
<b>Other</b>				
<input type="checkbox"/> Egrifta SV	2 mg	Inject 1.4 mg SQ once daily	QTY: 30	Refills: _____
			QTY: _____	Refills: _____

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