Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

# HIV REFERRAL FORM

| PATIENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | DOB: | Sex: ❑M ❑F | Weight: | ❑lbs. ❑kg. |
| SSN: | Phone: | Allergies: | | | |
| Address: | | City: | State: | Zip: | |
| Emergency Contact: | | Phone: | ❑**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 ASSESMENT**

***Primary Diagnosis:*** ❑B20 HIV / AIDS ❑R64 Cachexia (HIV Wasting) ❑B18.2 Hepatitis C (chronic) ❑B18.1 Hepatitis B ❑HIV-infected patients with abdominal lipodystrophy
❑Other:_____
CD4 count: _____, Viral Load/HIV RNA:_____, Hgb/Hct:_____, WBC/ANC:_____, CrCl:_____ (Please include copy of most recent labs)

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  _____

**PRESCRIPTION INFORMATION**

| Medication | Strength | Directions | QTY | Refills |
|---|---|---|---|---|
| **NRTIs** | | | | |
| ❑Emtriva | 200 mg | | QTY:____ | Refills:____ |
| ❑Epivir | ❑100 mg ❑150 mg ❑300 mg | | QTY:____ | Refills:____ |
| ❑Ziagen | ❑300 mg ❑4800 mg/240 mL | | QTY:____ | Refills:____ |
| **NNRTIs** | | | | |
| ❑Edurant | 25 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Intelence | ❑100 mg ❑200 mg | | QTY:____ | Refills:____ |
| ❑Pifeltro | 100 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Sustiva | ❑200 mg ❑600 mg | | QTY:____ | Refills:____ |
| **Combination Antiretrovirals** | | | | |
| ❑Atripla | 600 mg/200 mg/300 mg | 1 tab po daily on empty stomach (CrCl >50 mL/min) | QTY: 30 | Refills:____ |
| ❑Biktarvy | 50 mg/200 mg/25 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Complera | 200 mg/25 mg/300 mg | 1 tab po daily (CrCl >50 mL/min) | QTY: 30 | Refills:____ |
| ❑Delstrigo | 100 mg/300 mg/300 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Dovato | 50 mg/300 mg | 1 tab po daily (CrCL > 50 mL/min) | QTY: 30 | Refills:____ |
| ❑Epzicom | 600 mg/300 mg | 1 tab po daily (CrCl >50 mL/min) | QTY: 30 | Refills:____ |
| ❑Genvoya | 150 mg/150 mg/200 mg/10 mg | 1 tab po daily (CrCl >30 mL/min) | QTY: 30 | Refills:____ |
| ❑Juluca | 50 mg/25 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Odefsey | 25 mg/200 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Stribild | 150 mg/150 mg/200 mg/300 mg | 1 tab po daily (CrCl >70 mL/min) | QTY: 30 | Refills:____ |
| ❑Symfi | 600 mg/300 mg/300 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Symfi Lo | 400 mg/300 mg/300 mg | 1 tab po daily (preferably at bedtime) | QTY: 30 | Refills:____ |
| ❑Symtuza | 800 mg/150 mg/200 mg/10 mg | 1 tab po daily | QTY: 30 | Refills:____ |
| ❑Triumeq | 600 mg/50 mg/300 mg | 1 tab po daily (CrCl >50 mL/min) | QTY: 30 | Refills:____ |
| ❑Truvada | 200 mg/300 mg | ❑1 tab po daily (CrCl >50 mL/min)<br>❑1 tab po every 48 hours (CrCl 30-49 mL/min) | QTY: 30<br>QTY: 15 | Refills:____<br>Refills:____ |
| **Pharmacokinetic Enhancer** | | | | |
| ❑Norvir | 100 mg | ❑1 tab po daily with food<br>❑2 tab po daily with food | QTY: 30<br>QTY: 60 | Refills:____ |
| ❑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 electronic prescription or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed.**



Rev: 12.15.20

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
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# HIV REFERRAL FORM

| PATIENT INFORMATION | |
|---|---|
| Patient Name: | DOB: |
| **INSURANCE INFORMATION** | |
| **❑Please attach front and back of patient's insurance card (medical and prescription)** | |
| **COPAY CARD ENROLLMENT** | |
| **❑Please check if enrolling in copay card** | **Copay ID:** |

| Medication | Strength | Direction | QTY | Refills |
|---|---|---|---|---|
| **Integrase Inhibitors/CCR5 Inhibitors** | | | | |
| ❑Isentress | ❑25 mg ❑100 mg ❑400 mg | | QTY:____ | Refills:____ |
| ❑Isentress HD | 600 mg | 2 tabs po daily | QTY: 60 | Refills:____ |
| ❑Tivicay | ❑50 mg | | QTY:____ | Refills:____ |
| **Fusion Inhibitors** | | | | |
| ❑Fuzeon | 90 mg | 90 mg sq twice daily (CrCl > 35 mL/min) | QTY:____ | Refills:____ |
| **Protease Inhibitors** | | | | |
| ❑Prezista | ❑150 mg ❑60 mg<br>❑800 mg ❑100 mg/mL | | QTY:____ | Refills:____ |
| ❑Reyataz | ❑200 mg ❑300 mg | | QTY:____ | Refills:____ |
| **Boosted Protease Inhibitors** | | | | |
| ❑Evotaz | 300 mg/150 mg | | QTY:____ | Refills:____ |
| ❑Prezcobix | 800 mg/150 mg | | QTY:____ | Refills:____ |
| **Fusion/Attachment Inhibitors (Others)** | | | | |
| ❑Rukobia | 600 mg | 1 tab po twice daily | QTY: 30 | Refills:____ |
| ❑Selzentry | ❑150 mg ❑300 mg | 2 tab po twice daily | QTY: 120 | Refills:____ |
| **Other** | | | | |
| ❑Egrifta SV | 2 mg | Inject 1.4 mg SQ once daily | QTY: 30 | Refills:____ |
| | | | QTY:____ | Refills:____ |

**Prescriber's Signature:** _____ ❑ DAW (Dispense as Written) **Date:** _____

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