HIV Referral Form
Fax#: _____

Patient Information

Patient Name: _____ DOB: _____ Date:_____ SS#: _____

Ship to Address: _____ City: _____ State: _____ Zip: _____

Ship to: ___ Clinic ___ Patient's Home Allergies: _____

Statement of Medical Necessity & Prescription

HIV Medications

Diagnosis(ICD-10): B20 HIV Viral Load _____ CD4 _____

Fixed Dose Combinations

____ Atripla
____ Combivir
____ Epzicom
____ Genvoya
____ Trizivir
____ Truvada
____ Complera
____ Odefsey
___ Stribild
___ Triumeq
___ Prezcobyx
___ Descovy

Nucleoside Analogue Reverse Transcriptase Inhibitors (NRTI)

____ Emtriva
____ Epivir
____ Retrovir
____ Videx EC
____ Viread
____ Zerit
____ Ziagen

Protease Inhibitors (PI)

____ Aptivus
____ Invirase
____ Lexiva
____ Prezista
____ Viracept
____ Crixivan
____ Kaletra
____ Norvir
____ Reyataz
____ Agenerase

Non – Nucleoside Reverse Transcriptase Inhibitors (NNRTI)

____ Intelence
____ Sustiva
____ Edurant
____ Rescriptor
____ Viramune

Entry Inhibitors / Integrase Inhibitors

____ Fuzeon
____ Isentress
____ Selzentry
____ Tivicay

Adjunct Therapies

____ Serostim

Rx

Date: _____

Dosage / Quantity / Directions:

Refills: _____

Please Include The Following Information With this Prescription:

□ **Demographics Page**
□ **Front & Back Copy of the Patient's Prescription Insurance Card (if available)**
□ **Attach Any Additional Prescriptions if Applicable**

Physician Prescription Orders

Physician Name: _____ Phone: _____ Fax: _____

Address: _____ NPI #:_____ Nurse: _____

Physician Signature: _____ Date: _____

Substitution Permitted