

HIV Referral Form

Fax#: _____

Patient Information

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

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

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	___ Trizivir	___ Stribild
___ Combivir	___ Truvada	___ Triumeq
___ Epzicom	___ Complera	___ Prezcobix
___ Genvoya	___ Odefsey	___ Descovy
___ Juluca	___ Biktarvy	

Nucleoside Analogue Reverse Transcriptase Inhibitors (NRTI)

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

Protease Inhibitors (PI)

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

Non – Nucleoside Reverse Transcriptase Inhibitors (NNRTI)

___ Intelence	___ Rescriptor
___ Sustiva	___ Viramune
___ Edurant	

Entry Inhibitors / Integrase Inhibitors

___ Fuzeon	___ Selzentry
___ Isentress	___ 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