HIV Referral Form
Fax#: 844-635-5250

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
____ Combivir
____ Epzicom
____ Genvoya
____ Juluca
____ Delstrigo
____ Trizivir
____ Truvada
____ Complera
____ Odefsey
____ Biktarvy
____ Dovato
___ Stribild
___ Triumeq
___ Prezcobix
___ Descovy
___ Symtuza

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
____ Pifeltro

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