HIV REFERRAL FORM (Single Regimens)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment:				Therapy Start Date
Co-Infections? ☐ No ☐ Yes (please list)		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Has patient been treated previously for this condition? ☐ No ☐ Yes (please list medications)				
CD4 Count	Viral Load/HIV RNA	Serum Creatinine	Hgb/Hct	WBC/ANC
Allergies ☐ NKDA ☐ Drug Allergies (please list)			☐ Other Allergies (please list)	
Other/Concomitant Medications (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High risk heterosexual behavior
☐ High risk homosexual behavior
☐ High risk bisexual behavior
☐ Other: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
Single Regimens				
☐ Atripla *(brand no longer available; generic will be dispensed)*	☐ 600/200/300 mg			
☐ Biktarvy	☐ 50/200/25 mg			
☐ Cabenuva Injection Kit	☐ 600/900 mg ☐ 400/600 mg			
☐ Complera	☐ 200/25/300 mg			
☐ Delstrigo	☐ 100/300/300 mg			
☐ Dovato	☐ 50/300 mg			
☐ Genvoya	☐ 150/200/150/10 mg			
☐ Juluca	☐ 50/25 mg			
☐ Odefsey	☐ 200/25/25 mg			
☐ Stribild	☐ 150/150/200/300 mg			
☐ Symfi	☐ 600/300/300 mg			
☐ Symfi Lo	☐ 400/300/300 mg			
☐ Symtuza	☐ 800/150/200/10 mg			
☐ Triumeq	☐ 600/50/300 mg			

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0122

HIV REFERRAL FORM (NRTIs)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment:				Therapy Start Date
Co-Infections? ☐ No ☐ Yes (please list)		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Has patient been treated previously for this condition? ☐ No ☐ Yes (please list medications)				
CD4 Count	Viral Load/HIV RNA	Serum Creatinine	Hgb/Hct	WBC/ANC
Allergies ☐ NKDA ☐ Drug Allergies (please list)			☐ Other Allergies (please list)	
Other/Concomitant Medications (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High risk heterosexual behavior
☐ High risk homosexual behavior
☐ High risk bisexual behavior
☐ Other: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
NRTIs				
☐ Cimduo	☐ 300/300 mg			
☐ Combivir	☐ 150/300 mg			
☐ Descovy	☐ 200/25 mg			
☐ Emtriva	☐ 200 mg			
☐ Epivir	☐ 150 mg ☐ 300 mg			
☐ Epzicom	☐ 600/300 mg			
☐ Retrovir	☐ 100 mg			
☐ Trizivir	☐ 300/150/300 mg			
☐ Truvada	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg			
☐ Videx EC	☐ 125 mg ☐ 200 mg ☐ 250 mg ☐ 400 mg			
☐ Viread	☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg			
☐ Zerit	☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg			
☐ Ziagen	☐ 300 mg			
☐ Zidovudine	☐ 100 mg ☐ 300 mg			

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0122

HIV REFERRAL FORM (NNRTIs & Integrase Inhibitors)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment:			Therapy Start Date	
Co-Infections? ☐ No ☐ Yes (please list)	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Has patient been treated previously for this condition? ☐ No ☐ Yes (please list medications)				
CD4 Count	Viral Load/HIV RNA	Serum Creatinine	Hgb/Hct	WBC/ANC
Allergies ☐ NKDA ☐ Drug Allergies (please list)		☐ Other Allergies (please list)		
Other/Concomitant Medications (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High risk heterosexual behavior
☐ High risk homosexual behavior
☐ High risk bisexual behavior
☐ Other: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
NNRTIs				
☐ Edurant	☐ 25 mg			
☐ Intelence	☐ 25 mg ☐ 100 mg ☐ 200 mg			
☐ Pifeltro	☐ 100mg tablet	Take once daily with or without food		
☐ Sustiva	☐ 50 mg ☐ 200 mg ☐ 600 mg			
☐ Viramune	☐ 200 mg ☐ 50 mg/ 5 mL			
☐ Viramune XR	☐ 100 mg ☐ 400 mg			
Integrase Inhibitors				
☐ Apretude Injection Kit	☐ 600 mg			
☐ Isentress	☐ 400 mg			
☐ Isentress HD	☐ 600 mg			
☐ Tivicay	☐ 10 mg ☐ 25 mg ☐ 50 mg			
☐ Tivicay PD	☐ 5 mg			
☐ Vocabria		All referrals must be sent through the HUB, ViiV Connect. Phone: 1-844-588-3288; Fax 1-844-208-7676		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0122

HIV REFERRAL FORM (Protease Inhibitors, Entry Inhibitors & Pharmacokinetic Enhancer)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment:				Therapy Start Date
Co-Infections? ☐ No ☐ Yes (please list)	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Has patient been treated previously for this condition? ☐ No ☐ Yes (please list medications)				
CD4 Count	Viral Load/HIV RNA	Serum Creatinine	Hgb/Hct	WBC/ANC
Allergies ☐ NKDA ☐ Drug Allergies (please list)			☐ Other Allergies (please list)	
Other/Concomitant Medications (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High risk heterosexual behavior
☐ High risk homosexual behavior
☐ High risk bisexual behavior
☐ Other: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
Protease Inhibitors				
☐ Aptivus	☐ 250 mg ☐ 100 mg/mL			
☐ Evotaz	☐ 300/150 mg			
☐ Invirase	☐ 200 mg ☐ 500 mg			
☐ Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL			
☐ Lexiva	☐ 700 mg			
☐ Norvir	☐ 100 mg ☐ 80 mg/mL			
☐ Prezcobix	☐ 800/150 mg			
☐ Prezista	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg			
☐ Reyataz	☐ 150 mg ☐ 200 mg ☐ 300 mg			
☐ Viracept	☐ 250 mg ☐ 625 mg			
Entry Inhibitors:				
☐ Fuzeon	☐ 90 mg vial			
☐ Selzentry	☐ 150 mg ☐ 300 mg			
Pharmacokinetic Enhancer:				
☐ Tybost	☐ 150 mg			

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0122

HIV REFERRAL FORM (Miscellaneous)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City		State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)		Alt Contact Email			Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email		Office Phone	Office Fax	
Practice / Facility Name		Prescriber Name / Specialty		
Address		City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment:				Therapy Start Date
Co-Infections? ☐ No ☐ Yes (please list)		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Has patient been treated previously for this condition? ☐ No ☐ Yes (please list medications)				
CD4 Count	Viral Load/HIV RNA	Serum Creatinine	Hgb/Hct	WBC/ANC
Allergies ☐ NKDA ☐ Drug Allergies (please list)			☐ Other Allergies (please list)	
Other/Concomitant Medications (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				

ICD-10 Code

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High risk heterosexual behavior
☐ High risk homosexual behavior
☐ High risk bisexual behavior
☐ Other: _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
Miscellaneous:				
☐ Azithromycin				
☐ Bactrim				
☐ Diflucan				
☐ Egrifta SV		All referrals must be sent through the HUB, Egrifta Assist. Phone: 1-844-EGRIFTA or 1-844-347-4382; Fax 1-855-836-3069		
☐ Rukobia	☐ 600 mg Extended-Release			
☐ Trogarzo		All referrals must be sent through the HUB, Trogarzo Assist. Phone: 1-(833)-238-4372 Fax 1-(855)-836-3069		
Other:				
☐				
☐				
☐				

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.0122