HIV REFERRAL FORM (Single Regimens)

PHONE 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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	ON												
Last Name	First Name	DO	ОВ		Gender □ M	□F	Last 4 SSN			Primary La	nguage		
Address				City				State			ZIP		
Email	Hom	e Phone			Work Pho	one				Cell Pho	one		
Primary Contact Method (c	heck one) Cell Phone	☐ Home Phone	☐ Work Phone	e 🗆 Te	xt 🗆 Email	□ Pri	imary Caregive	r 🗆 DO	ТОИС	CONTACT			
Primary Caregiver/Alt Conta	act Name (If applicable)		Alt Conta	ct Email						Alt Contac	t Phone		
PRESCRIBER INFORM	MATION												
Name of Contact Sending R	eferral		Title				erred Contact N	1ethod (c	T		nail 🗆 Pho	one [Fax
Referral Contact Email					Office Phone				Offic	e Fax			
Practice / Facility Name			,	T	Prescriber Na	ame / s	Specialty			T -		l	
Address					ity	-				State		ZIP	
Prescriber State License #	DEA #	a in aluala a			PI #	1 5		ual *	Medica	aid UPIN #			
		e include a			t and paci	K OT	insurance	cara "					
CLINICAL INFORMAT				iotes									
	Naïve/New Start Therapy	/ Restart □ Exi	sting Treatment:					Therapy S					
Co-Infections? No Yes					atient Height (d	cm/in):	: Weig)s): 	Dat	e Obtained:	-		
	eviously for this condition?	□ No □ Yes (pl											
CD4 Count	Viral Load/HIV RNA		Serum Creatinir			Hgb/l				WBC/ANC			
Allergies □ NKDA □ Drug					☐ Other Allerg	ies (pie	ease list)						
Other/Concomitant Medicat		041		-			-		-				
Ship to Address		Other (please list			High risk home		I babardan						
□ z:	20 Human Immunodeficienc 20.6 Contact with and (susp 72.51 High risk heterosexual	ected) exposure t			High risk bisex Other:								
PRESCRIPTION INFO							" 5						
In order for a brand name or your state-specific req											s.		
MEDICATION	DOSE	DIRECT	IONS								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												
	1	I									ı		
Prescriber Signature		Date		S	upervising Phy	/sician	Signature (whe	ere requir	ed by s	tate law)	Date		
DAW (Dispense as Written)		Date		В	Brand Necessar	y (mus	st handwrite)						

HIV REFERRAL FORM (NRTIs)

PHONE 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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	NC													
Last Name	First I	Name	D	ОВ		Gender □ M	□F	Last 4 SSN			Primary La	nguage		
Address					City				State	•		ZIP		
Email	Home Phone					Work Phone Cell Phone								
Primary Contact Method (cl	heck one) Cel	I Phone	e Phone	☐ Work Phone	e 🗆 Te	xt 🗆 Email	□ Pr	imary Caregive	r 🗆 DO	тоис	CONTACT			
Primary Caregiver/Alt Conta	ct Name (If applic	cable)		Alt Conta	ct Email						Alt Contact	t Phone		
PRESCRIBER INFORM	1ATION			1										
Name of Contact Sending R	eferral			Title		T		erred Contact N	Method (c	1		nail 🗆 Pho	ne 🗆	Fax
Referral Contact Email						Office Phon				Offic	e Fax			
Practice / Facility Name						Prescriber N	lame / :	Specialty			1 -			
Address						ity					State		ZIP	
Prescriber State License #		DEA#	luda a			PI #	1 6	inarwanaa	ual *	Medic	aid UPIN #			
		* Please inc				t and bac	ког.	insurance	cara "					
CLINICAL INFORMAT														
Patient New to Therapy N		☐ Therapy Resta	rt □ Exi	sting Treatment:					Therapy S					
Co-Infections? ☐ No ☐ Yes	-					atient Height (: Weig	Date	e Obtained:					
Has patient been treated pro			⊔ Yes (pl											
CD4 Count	Viral Load/F			Serum Creatinin			Hgb/I				WBC/ANC			
Allergies NKDA Drug		list)				☐ Other Aller	gies (pi	ease list)						
Other/Concomitant Medicat			!! . 4											
Ship to Address	☐ Prescriber's O			-		High risk hom		l bobovior						
□ z 2	20 Human Immund 20.6 Contact with 72.51 High risk het	and (suspected)	exposure			High risk bise Other:								
PRESCRIPTION INFO														
In order for a brand name or your state-specific req												5.		
MEDICATION	DOSE		DIRECT	IONS								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 □ 167/250 mg	□ 133/200 mg □ 200/300 mg												
□ Videx EC	□ 125 mg □ 250 mg	□ 200 mg □ 400 mg												
□ Viread	□ 150 mg □ 250 mg	□ 200 mg □ 300 mg												
□ Zerit	□ 15 mg □ 30 mg	□ 20 mg □ 40 mg												
☐ Ziagen	□ 300 mg													
□ Zidovudine	□ 100 mg	□ 300 mg												
Prescriber Signature			Date		S	Supervising Ph	ysician	Signature (whe	ere requir	ed by s	tate law)	Date		_
DAW (Dispense as Written)			Date		- E	Brand Necessa	ry (mus	st handwrite)						

HIV REFERRAL FORM (NNRTIS & Integrase Inhibitors)

PHONE 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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	ON										
Last Name	First Name	DOB		Gender \square M	□F	Last 4 SSN		Primary Lan	guage		
Address			City				State		ZIP		
Email	Home Phon	e		Work Pho	one			Cell Phor	ne		
Primary Contact Method (ch	neck one) 🗆 Cell Phone 🗆 Hom	ne Phone	one □ Te	ext 🗆 Email	□ Pri	imary Caregiver		T CONTACT			
Primary Caregiver/Alt Conta	ct Name (If applicable)	Alt Con	itact Email	I				Alt Contact	Phone		
PRESCRIBER INFORM	IATION										
Name of Contact Sending Re	eferral	Title			Prefe	erred Contact Me	thod (check	cone) □Ema	ail 🗆 Phone	□ Fax	
Referral Contact Email		<u>'</u>		Office Phone			Of	ffice Fax			
Practice / Facility Name				Prescriber Na	ame / s	Specialty					
Address			С	ity				State	ZII	P	
Prescriber State License #	DEA#		N	IPI #			Med	dicaid UPIN #			
	* Please inc	lude a copy of t	he fron	nt and bac	k of	insurance c	ard *				
CLINICAL INFORMAT	ION - Please include applic	cable clinical chart	t notes								
Patient New to Therapy □ N	aïve/New Start □ Therapy Resta	rt 🗆 Existing Treatme	nt:		Date						
Co-Infections? ☐ No ☐ Yes	(please list)		P	atient Height (d	:m/in):	: Weigh	t (kg/lbs):	Date	Obtained:		
Has patient been treated pre	eviously for this condition?	☐ Yes (please list medic	cations)								
CD4 Count	Viral Load/HIV RNA	Serum Creati	inine		Hgb/l	Hct		WBC/ANC			
Allergies □ NKDA □ Drug				☐ Other Allerg							
Other/Concomitant Medicati						<u> </u>					
Ship to Address ☐ Home	☐ Prescriber's Office ☐ Other (please list)									
· · · · · · · · · · · · · · · · · · ·	O Human Immunodeficiency Virus	· · · · · · · · · · · · · · · · · · ·		High risk home	osexua	l behavior					
□ Z 2	20.6 Contact with and (suspected) 22.51 High risk heterosexual behavio	exposure to HIV		High risk bisex Other:				_			
PRESCRIPTION INFO	RMATION - Please Escribe	if required by stat	te law			"D IM "	" "				
	e product to be dispensed, the uired language to prohibit sub										
MEDICATION	DOSE	DIRECTIONS							QTY	REFILLS	
NNRTIs											
□ Edurant	□ 25 mg										
□ Intelence	□ 25 mg □ 100 mg □ 200 mg									+	
□ Pifeltro	□ 100mg tablet	Take once daily with o	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 s Phone: 1-844-588-328			V Conn	nect.					
			-								
Prescriber Signature		Date	9	Supervising Phy	sician	Signature (where	e required b	y state law)	Date		
DAW (Dispense as Written)		Date	- E	Brand Necessar	y (mus	st handwrite)					

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.

HIV REFERRAL FORM (Protease Inhibitors, Entry Inhibitors & Pharmacokinetic Enhancer) **PHONE** 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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	ОИ																		
Last Name	First N	lame	D	ОВ			Gen	der 🗆 M	□F	Last 4 SS	SN		Pri	imary La	nguage				
Address					City						State			ZIP					
Email	Home Phone						Work Phone Cell Phone								one				
Primary Contact Method (cl	heck one) Cell	Phone	me Phone	□Wo	ork Phone	□т	ext	□ Email	□ Pri	mary Care	giver		от сс	NTACT					
Primary Caregiver/Alt Conta	act Name (If applic	able)		A	Alt Contac	ct Ema	il						Alt	t Contac	t Phone				
PRESCRIBER INFORM	MATION																		
Name of Contact Sending R	eferral			Title					Prefe	erred Conta	act Metl	hod (che	ck one) □ En	nail 🗆 Ph	one	□Fax		
Referral Contact Email							Off	ice Phone				(Office I	Fax					
Practice / Facility Name							Pre	scriber Na	ame / S	Specialty									
Address							City							State		ZIP			
Prescriber State License #		DEA#					NPI#						edicaio	I UPIN #					
		* Please in						nd baci	k of I	insuran	ce ca	rd *							
CLINICAL INFORMAT	ION - Please ii	nclude appl	icable cl	linical	chart n	otes													
Patient New to Therapy N	laïve/New Start	☐ Therapy Rest	art 🗆 Exi	isting Tr	eatment:						The	rapy Star	t Date						
Co-Infections? ☐ No ☐ Yes	(please list)					1	Patient	t Height (c	:m/in):	'	Weight	(kg/lbs):		Dat	e Obtained	:			
Has patient been treated pro	eviously for this co	ndition? 🗆 No	☐ Yes (pl	lease list	t medicat	ions)													
CD4 Count	Viral Load/H	IV RNA		Serum	Creatinin	ne			Hgb/H	Hct			WI	BC/ANC					
Allergies □ NKDA □ Drug	Allergies (please li	ist)					□ Otl	her Allergi	es (ple	ease list)									
Other/Concomitant Medicat	ions (please list)																		
Ship to Address ☐ Home	☐ Prescriber's Of	ffice	(please list	t)															
□ z 2	20 Human Immuno 20.6 Contact with a 72.51 High risk hete	and (suspected)	exposure			[risk bisex		l behavior havior									
PRESCRIPTION INFO In order for a brand name or your state-specific req	e product to be o	dispensed, the	e prescrib	er mus	t handw	rite "I									s.				
MEDICATION	DOSE		DIRECT												QTY		REFILLS		
Protease Inhibitors																			
☐ Aptivus	□ 250 mg □ 100	mg/mL																	
□ Evotaz	□ 300/150 mg																		
□ Invirase	□ 200 mg □ 5	00 mg																	
□ Kaletra	□ 100/25 mg □ □ 80 mg - 20 mg																		
□ Lexiva	□ 700 mg																		
□ Norvir	□ 100 mg □	80 mg/mL																	
☐ Prezcobix	□ 800/150 mg																		
☐ Prezista		150 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		_		Super	vising Phy	sician	Signature	(where	required	by sta	te law)	Date		_		
DAW (Dispense as Written)			Date				Brand	Necessar	y (mus	t handwrit	e)								

HIV REFERRAL FORM (Miscellaneous)

PHONE 888.370.1724 | **FAX** 877.645.7514

obtain instructions as to proper destruction of the transmitted material.



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PATIENT INFORMATION	ON											
Last Name	First Name	DOB		Gender □ M	□F	Last 4 SSN		Prim	ary Langu	age		
Address	·		City				State		ZI	Р		
Email	Home F	Phone		Work Ph	one			(Cell Phone			
Primary Contact Method (ch	neck one) 🗆 Cell Phone 🗆	Home Phone	ne 🗆 Te	ext 🗆 Email	□ Pr	imary Caregiver	□ DO 1	OT CON	TACT			
Primary Caregiver/Alt Conta	ct Name (If applicable)	Alt Cont	tact Emai	il				Alt (Contact Ph	one		
PRESCRIBER INFORM	ATION											
Name of Contact Sending Re	eferral	Title			Pref	erred Contact M	ethod (che	ck one)	□ Email	☐ Phone	□ Fax	
Referral Contact Email				Office Phone	•			Office Fa	x			
Practice / Facility Name				Prescriber N	ame /	Specialty						
Address			(City				St	ate	ZI	P	
Prescriber State License #	DEA #		1	NPI#			м	edicaid l	JPIN#	ļ.		
	* Please	include a copy of th	he froi	nt and bac	k of	insurance d	card *					
CLINICAL INFORMATI	ON - Please include ap			nt and bac		modramee (.a, a					
	<u> </u>	·										
	aïve/New Start	estart					herapy Sta			Ohtobard .		
Co-Infections? ☐ No ☐ Yes				Patient Height (cm/in)	: Weig	ht (kg/lbs)		Date OI	Date Obtained:		
Has patient been treated pre	eviously for this condition?	No 🗆 Yes (please list medic	ations)									
CD4 Count	Viral Load/HIV RNA	Serum Creatir	nine		Hgb/	Hct		WBC	C/ANC			
Allergies □ NKDA □ Drug	Allergies (please list)			☐ Other Allerg	ies (pl	ease list)						
Other/Concomitant Medicati	ons (please list)											
Ship to Address ☐ Home	☐ Prescriber's Office ☐ Oth	ner (please list)										
□ Z2	O Human Immunodeficiency V O.6 Contact with and (suspect	ed) exposure to HIV		☐ High risk hom								
	2.51 High risk heterosexual bel			☐ Other:								
	RMATION - Please Escri product to be dispensed,			Brand Necess	arv" o	r "Brand Medio	cally Nece	essarv"				
	uired language to prohibit								ations.			
MEDICATION	DOSE	DIRECTIONS								QTY	REFILLS	
Miscellaneous:												
☐ Azithromycin												
□ Bactrim												
□ Diflucan												
☐ Egrifta SV		All referrals must be se	ent throu	ah the HUR Fa	rifta Δ·	ssist						
_ Lgiiita 5v		Phone: 1-844-EGRIFTA Fax 1-855-836-3069				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
☐ Rukobia	☐ 600 mg Extended-Release											
☐ Trogarzo		All referrals must be se Phone: 1-(833)-238-43		gh the HUB, Tro	garzo	Assist.						
		Fax 1-(855)-836-3069	72									
Other:												
Prescriber Signature		Date		Supervising Phy	/sician	Signature (whe	re required	by state	law)	Date		
DAW (Dispense as Written)		Date		Brand Necessar								