Date Shipment Needed:_____ Ship To: ☐ Patien ☐ Physician ☐ Nursing needed ☐ Training needed
► All the supplies including syringes and needles will be dispensed if needed.

HIV / AIDS Referral Form

Patient Name: _____
Home Phone: (___)_____-_____ Work Phone: (___)_____-_____
Cell Phone: (_____)_____- _____
Emergency Contact Name (Required): _____
Emergency Contact Phone # (Required): (_____) _____- _____
Patient Soc. Sec #:_____ Allergies:_____
Date of Birth:____/____/____ Sex: ❑M ❑F Weight:_____ ❑ l bs ❑kg
Patient ethnicity:_____
❑ See attached demographic sheet Height:_____ BSA_____ m²

Physician Name:_____
State Lic #_____ DEA # _____
NPI #_____ Specialty: _____
Practice Name/Hospital: _____
Address:_____
City:_____ State:_____ Zip:_____
Physician's Phone: (_____)_____ - _____
Physician's Fax: (_____)_____-_____
Nurse/Key Office Contact: _____

INSURANCE INFORMATION (Complete or attach copies of cards)

Primary Insurance:_____
City:_____ State:_____
Plan #: _____
Group#: _____
Phone: (_____) -_____-_____

Secondary Insurance:_____
City:_____ State:_____
Plan #: _____
Group#: _____
Phone: (_____) -_____-_____

Rx Card (PBM):_____
PBM BIN: _____
City:_____ State:_____
Group#: _____
Phone: (_____) -_____-_____

Cardholder First Name: _____
Last Name: _____
Employer: _____
ID#: _____
Group#:_____

DIAGNOSTIC INFORMATION

❑B20 HIV / AIDS ❑R64 Cachexia (HIV Wasting) ❑B18.2 Hepatitis C (chronic) ❑B18.1 Hepatitis B ❑HIV-infected patients with abdominal lipodystrophy ❑Other:_____
CD4 count:_____, Viral Load/HIV RNA:_____, Hgb/Hct:_____, WBC/ANC:_____, CrCl:_____ (Please include copy of most recent labs)

STATEMENT OF MEDICAL NECESSITY

Has patient previously been on therapy? ❑Yes ❑No List of previous meds_____
Is patient currently on therapy? ❑Yes ❑No List of current meds_____
Will any of the above medications be discontinued when patient starts on the new therapy? ❑Yes ❑No List of meds to be discontinued _____
(*Note: Fuzeon must be taken as part of a combination antiviral regimen*)
Is patient currently taking any other medications? ❑Yes ❑No List of medications_____
Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____

PRESCRIPTION INFORMATION (*One month supply will be dispensed unless quantity is indicated*)

Medication	Strength (mg)	Directions	Qty	Refill
NRTIs				
❑Emtriva	❑200	___Caps ____Time(s)/day		
❑Epivir	❑150 ❑300	___Tabs ____Time(s)/day		
❑Retrovir	❑100 ❑50mg/5mL	___Caps ____Tabs ____Time(s)/day ___mLs ____Time(s)/day		
❑Viread	❑150 ❑300	___Tabs ____Time(s)/day		
❑Zerit	❑30 ❑40	___Caps ____Time(s)/day		
❑Ziagen	❑300 ❑480mg/240mL	___Tabs ____Time(s)/day ___mLs ____Time(s)/day		
NNRTIs				
❑Intelence	❑100 ❑200	___Tabs ____Time(s)/day		
❑Rescriptor	❑400	___Tabs ____Time(s)/day		
❑Sustiva	❑200 ❑600	___Caps ____ Tabs ____Time(s)/day		
❑Viramune	❑200❑400XR ❑50mg/5mL	____Tabs ____Time(s)/day ____mLs ____Time(s)/day		
Combination Antiretrovirals				
❑Atripla	600/200/300	1 tab po Daily on empty stomach	30	
❑Combivir	150/300	1 tab po BID (CrCl > 50ml/min)	60	
❑Complera	200/25/300	1 tab po Daily (CrCl >50ml/min)	30	
❑Epzicom	600/300	1 tab po Daily(CrCl >50ml/min)	30	
❑Genvoya	150/150/200/10	1 tab po Daily(CrCl >30ml/min)	30	
❑Kaletra	❑100/25❑200/50	___Tabs ____Time(s)/day		
❑Stribild	150/150/200/300	1 tab po Daily (CrCl >70ml/min)	30	
❑Trizivir	300/150/300	1 tab po BID (CrCl > 50ml/min)	60	
❑Triumeq	600/50/300	1 tab po Daily (CrCl >50ml/min)	30	
❑Truvada	200/300	❑1 tab po Daily (CrCl > 50ml/min) ❑1 tab po Q48hr (CrCl 30-49ml/min)	30 15	
Pharmacokinetic Enhancer				
❑Tybost	150	1 tab po Daily with food	30	

Medication	Strength (mg)	Directions	Qty	Refill
Protease Inhibitors				
❑Aptivus	❑250 ❑100mg/mL	___Caps ____Time(s)/day ___mLs ____Time(s)/day		
❑Crixivan	❑200 ❑400	___Caps ____Time(s)/day		
❑Invirase	❑200 ❑500	___Caps ____Time(s)/day ___Tabs ____Time(s)/day		
❑Lexiva	❑700	___Tabs ____Time(s)/day		
❑Norvir	❑100 ❑80mg/mL	___Caps ___Tabs ___Time(s)/day ___mLs ____Time(s)/day		
❑Prezista	❑150 ❑600 ❑800 ❑100mg/mL	___Tabs ____Time(s)/day ___mLs ____Time(s)/day		
❑Reyataz	❑200 ❑300	___Caps ____Time(s)/day		
❑Viracept	❑250 ❑625	___Tabs ____Time(s)/day		
Integrase Inhibitors / CCR5 Inhibitors				
❑Isentress	❑25 ❑100 ❑400	___Tabs ____Time(s)/day		
❑Selzentry	❑150 ❑300	___Tabs ____Time(s)/day		
❑Tivicay	❑50	___Tabs ____Time(s)/day		
❑Vitekta	❑85 ❑150	___Tabs ____Time(s)/day w food		
Boosted Protease Inhibitors				
❑Evotaz	300/150	___Tabs ___Time(s)/day w food		
❑Prezcobix	800/150	___Tabs ___Time(s)/day		
N(t)RTIs				
❑Edurant	25	___Tabs ___Time(s)/day		
❑Emtriva	200	___Caps ___Time(s)/day		
❑Videx EC	❑250 ❑400	___Caps ___Time(s)/day		
Fusion Inhibitors				
❑Fuzeon	90	90mg SQBID (CrCl > 35ml/min)		
Other				
❑Other		___Caps ____Tabs ___Time(s)/day		

Physician Signature:_____ ❑DAW (Dispense As Written) **Date:**_____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

Phone: 800-511-5144 Fax: 877-541-1503