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	Home Phone					Work Phone Cell Phone							
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	ght (kg/lb)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



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	Fi	irst Name	D	ОВ		Gender □ M	□F	Last 4 SSN		Pr	imary Langu	ıage				
Address					City				State		Z	IP				
Email		Home Phone				Work Ph	one				Cell Phone					
Primary Contact Method (cl	heck one)	Cell Phone ☐ Hom	e Phone	☐ Work Phon	e 🗆 To	ext 🗆 Email	□ Pr	imary Caregiv	ver 🗆 DC	NOT CO	NTACT					
Primary Caregiver/Alt Conta	ct Name (If ap	oplicable)		Alt Conta	act Ema	il				Al	t Contact Ph	none				
PRESCRIBER INFORM																
Name of Contact Sending R				Title			Pref	erred Contact	t Method (cl	heck one) 🗆 Email	☐ Phone	□ Fax			
Referral Contact Email						Office Phone				Office						
Practice / Facility Name						Prescriber N	ame /	Specialty								
Address						City					State	ZI	P			
Prescriber State License #		DEA #				NPI #				Medicai	d UPIN #					
		* Please inc	lude a	copy of th			k of	insurance	e card *							
CLINICAL INFORMAT	ION - Plan					it and bac	κ ο,	mounance	cara							
Patient New to Therapy N		rt ⊔Therapy Restar	t ⊔Exi	sting Treatment					Therapy S							
Co-Infections? ☐ No ☐ Yes						Patient Height (cm/in):			eight (kg/lb	s):	Date O					
Has patient been treated pro			□ Yes (pl													
CD4 Count	Viral Loa	ad/HIV RNA		Serum Creatin	ine		Hgb/	Hct		W	BC/ANC					
Allergies □ NKDA □ Drug	Allergies (plea	ase list)				☐ Other Allerg	jies (pl	ease list)								
Other/Concomitant Medicat	ions (please li	st)														
Ship to Address ☐ Home	☐ Prescriber	r's Office ☐ Other (p	lease list	:)												
□ z 2	20.6 Contact v	nunodeficiency Virus (vith and (suspected) e heterosexual behavio	exposure			☐ High risk hom ☐ High risk bise ☐ Other:										
PRESCRIPTION INFO	e product to	be dispensed, the	orescrib	er must hand	write "E											
or your state-specific req		ige to prombit subs			not a v	aliu prescripi	.1011 10	riii ior writii	rig control	ieu mec	ilcations.	o TV	- Francis			
MEDICATION NRTIs	DOSE		DIRECT	TONS								QTY	REFILLS			
	□ 700/700 ×															
☐ Cimduo	□ 300/300 r															
☐ Combivir	□ 150/300 m															
☐ Descovy	□ 200/25 mg	9														
☐ Emtriva	□ 200 mg															
☐ Epivir	□ 150 mg	□ 300 mg														
☐ Epzicom	□ 600/300 r	ng														
☐ Retrovir	□ 100 mg															
☐ Trizivir	□ 300/150/3	600 mg														
□ Truvada	□ 100/150 m □ 167/250 m															
□ 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			Supervising Ph	ysician	Signature (w	here require	ed by sta		Date				
DAW (Dispense as Written)			Date			Brand Necessa	ry (mu	st handwrite)								

HIV REFERRAL FORM (NNRTIS & Integrase Inhibitors)

PHONE 888.370.1724 | **FAX** 877.645.7514



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			Gend	er 🗆 M	□F	Last 4 S	SN		Pri	mary Langı	uage			
Address						City						State		z	IP			
Email		Home Phone	9				,	Work Ph	one					Cell Phone	•			
Primary Contact Method (cl	heck one) 🗆 Cell	Phone	e Phone	□ Wor	rk Phone	□те	ext [Email	□ Pr	imary Care	giver	□ DC	NOT CO	NTACT				
Primary Caregiver/Alt Conta	ct Name (If applic	able)		Al	It Contact	t Emai	il						Alt	Contact Pl	hone			
PRESCRIBER INFORM	1ATION																	
Name of Contact Sending Re	eferral			Title					Pref	erred Cont	act Me	thod (cl	neck one)	□ Email	☐ Phor	ne	□ Fax	
Referral Contact Email							Offic	e Phone	9				Office F	ax				
Practice / Facility Name							Pres	criber N	ame /	Specialty								
Address						(City					-		State	ZIP			
Prescriber State License #		DEA#				1	NPI#						Medicaid	UPIN#				
		* Please incl	lude a	copy	of the	froi	nt an	d bac	k of	insuran	ce ca	ard *						
CLINICAL INFORMAT	ION - Please i																	
Patient New to Therapy ☐ N						J.03					The	orany S	tart Date					
Co-Infections? ☐ No ☐ Yes		_ Therapy Restar		isting ne	atment.		Dationt	Height (cm/in)	Therapy Start D n): Weight (kg/lbs):				Date Obtained:				
		unditions The	□ Vaa (ml	aaaa liat			atient	neight (C111/1117		vveigiii	. (kg/lb	s).	Date C	btained.			
Has patient been treated pre			⊔ res (pi						11-1-7	11-4			14/5	20 /4 N/0	- 4			
CD4 Count	Viral Load/H			Serum (Creatinine	9	=		Hgb/				BC/ANC					
Allergies □ NKDA □ Drug		ist)					□Oth	er Allerg	iles (pl	ease list)								
Other/Concomitant Medicat																		
Ship to Address ☐ Home	☐ Prescriber's O	ffice	lease list	:)														
□ z 2	20 Human Immund 20.6 Contact with 72.51 High risk hete	and (suspected) e	xposure					isk bise		l behavior havior								
PRESCRIPTION INFO	RMATION - PI	ease Escribe i	if requi	red by	state l	aw												
In order for a brand name or your state-specific req																		
		to prombit subs			OTTIT IS TI	ot a v	ranu pi	escript	1011 10	riii ior wr	itilig t	.OHLFOI.	ieu meu	ications.	OTV.		DEFILLS	
MEDICATION	DOSE		DIRECT	IONS											QTY		REFILLS	
NNRTIS																		
☐ Edurant	□ 25 mg																	
☐ Intelence	□ 25 mg □ 100	mg □ 200 mg																
□ Pifeltro	□ 100mg tablet		Take on	ice daily	with or w	ithout	food											
☐ Sustiva	□ 50 mg □ 200	mg □ 600 mg																
☐ Viramune	□ 200 mg □ 50	mg/ 5 mL																
☐ Viramune XR	□100 mg □40	0 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 refe	rrals mus	t be sent	throu	ah the	HUB. Vii	V Conr	nect.								
					8-3288; F													
Prescriber Signature			Date		_		Superv	ising Ph	ysician	Signature	(where	require	ed by stat	e law)	Date			
DAW (Dispense as Written)			Date		_		Brand I	Necessai	rv (mus	st handwrit	.e)							

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, fav

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



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PATIENT INFORMATION	NC														
Last Name	First	t Name	D	ОВ		Ger	nder 🗆 M	□F	Last 4 SSI	N		Prin	nary Langu	age	
Address					City	,					State		ZII	P	
Email		Home Phone	9				Work Ph	one				(Cell Phone		
Primary Contact Method (cl	heck one) 🗆 Ce	ell Phone	e Phone	□ Work F	Phone 🗆	Text	☐ Email	□ Pr	imary Careg	iver		IOT CON	ITACT		
Primary Caregiver/Alt Conta	ct Name (If appl	licable)		Alt C	Contact Em	ail						Alt	Contact Ph	one	
PRESCRIBER INFORM	IATION														
Name of Contact Sending Re	eferral			Title				Pref	erred Conta	ct Meth	od (che	ck one)	□ Email	☐ Phone	□ Fax
Referral Contact Email						Of	ffice Phone	•				Office Fa	ıx		
Practice / Facility Name						Pr	escriber N	ame /	Specialty						
Address						City						St	ate	Z	IP
Prescriber State License #		DEA#				NPI#					М	edicaid (JPIN#		
		* Please incl	lude a	сору от	f the fro	ont a	nd bac	k of	insuranc	e cai	rd *				
CLINICAL INFORMAT	ION - Please	include applic	able c	linical cha	art notes	s									
Patient New to Therapy ☐ N	laïve/New Start	☐ Therapy Restar	t □Ex	isting Treatr	nent:					Ther	apy Sta	rt Date			
Co-Infections? ☐ No ☐ Yes	(please list)					Patient Height (cm/			m/in): Weight (kg/lbs):				Date Ok	otained:	
Has patient been treated pre	eviously for this	condition? 🗆 No	□ Yes (p	lease list me	edications)										
CD4 Count	Viral Load/	/HIV RNA		Serum Cre	atinine			Hgb/	Hct			WB	C/ANC		
Allergies □ NKDA □ Drug	Allergies (please	e list)				□ O1	ther Allerg	ies (pl	ease list)						
Other/Concomitant Medicat															
Ship to Address ☐ Home		Office	lease lis	t)											
-		nodeficiency Virus (-		□ Hial	h risk hom	osexua	l behavior						
□ z 2	20.6 Contact wit	h and (suspected) e eterosexual behavio	xposure				h risk bise								
PRESCRIPTION INFO															
In order for a brand name or your state-specific req													cations		
MEDICATION	DOSE	e to prombit subs	DIRECT		11 13 1101 0	vana	presempe	101110	TITI TOT WITE	ing co	inti one	a mean	ations.	QTY	REFILLS
	DOSE		DIREC	IIONS										GII	REFILLS
Protease Inhibitors	□ 250 mm □ □ 14	00 (1												1	
☐ Aptivus	□ 250 mg □ 10	00 mg/mL													
□ Evotaz	□ 300/150 mg														
☐ Invirase] 500 mg													
□ Kaletra	□ 100/25 mg □ 80 mg - 20 m														
□ Lexiva	□ 700 mg														
□ Norvir	□ 100 mg	□ 80 mg/mL													
☐ Prezcobix	□ 800/150 mg														
□ Prezista		□ 150 mg □ 800 mg													
□ Reyataz	□ 150 mg □ 20	00 mg □ 300 mg													
□ Viracept	□ 250 mg	□ 625 mg													
Entry Inhibitors:															
□ Fuzeon	☐ 90 mg vial														
☐ Selzentry		□ 300 mg													
Pharmacokinetic Enhancer:															
☐ Tybost	□ 150 mg														
_ Iybost	_ iso ing														
Prescriber Signature			Date			Supe	ervising Phy	ysician	Signature (\	where r	equired	by state	law)	Date	
DAW (Dispense as Written)			Date			Brand	d Necessar	y (mus	st handwrite)					

HIV REFERRAL FORM (Miscellaneous)

PHONE 888.370.1724 | **FAX** 877.645.7514



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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	P	
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				
Co-Infections? ☐ No ☐ Yes				Patient Height (cm/in)	: Weig	ht (kg/lbs)		Date OI	otained:	
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							