HIV REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049

PHONE: +1(844) 650-5802

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: ____________ **DOB:** ____________ **Gender:** ☐ MALE ☐ FEMALE
Address: ____________ **City/State/Zip:** ____________
Primary Phone: ____________ **Email:** ____________ **SSN:** ____________ **Primary Language:** ____________
Emergency Contact: ____________ **Relationship to Patient:** ____________ **Phone:** ____________

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary RX Insurance:____________ **ID No:**____________ **RX GRP:**____________ **RX BIN:**____________ **RX PCN:**____________

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10): DXr Code: ____________ Description: ____________

Patient Clinical Information: **Drug Allergies**:____________ ☐ NKDA **Ht:** ____________in/cm **Wt:** ____________lbs/Kg

CD4 Count: ________ **Baseline Viral load:** ________ *Date of labs:* _____/_____/_____

Coinfection: ☐ None ☐ HCV ☐ HBV **HLA-B*5701 test**: ☐ Negative Positive

4 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
SINGLE REGIMEN ORAL:				
☐ Biktarvy	☐ 50/200/25 mg	Other: ____________	______	______
☐ Complera	☐ 200/25/300 mg	Other: ____________	______	______
☐ Delstrigo	☐ 100/300/300 mg	Other: ____________	______	______
☐ Dovato	☐ 50/300 mg	Other: ____________	______	______
☐ Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate	☐ 600/200/300 mg	Other: ____________	______	______
☐ Juluca	☐ 50/25 mg	Other: ____________	______	______
☐ Odefsey	☐ 200/25/25 mg	Other: ____________	______	______
☐ Stribild	☐ 150/150/200/300 mg	Other: ____________	______	______
☐ Symfi	☐ 600/300/300 mg	Other: ____________	______	______
☐ Symfi Lo	☐ 400/300/300 mg	Other: ____________	______	______
☐ Symtuza	☐ 800/150/200/10 mg	Other: ____________	______	______
☐ Triumeq	☐ 600/50/300 mg	Other: ____________	______	______
☐ Triumeq PD	☐ 60/5/30 mg	Other: ____________	______	______
NRTIs:				
☐ Cimduo	☐ 300/300 mg	Other: ____________	______	______
☐ Lamivudine/ Zidovudine **Brand no longer available for this drug*	☐ 150/300 mg	Other: ____________	______	______
☐ Descovy	☐ 200/25 mg	Other: ____________	______	______
☐ Emtriva	☐ 200 mg	Other: ____________	______	______
☐ Epivir	☐ 150 mg ☐ 300 mg	Other: ____________	______	______
☐ Abacavir/ Lamivudine	☐ 600/300 mg	Other: ____________	______	______
☐ Retrovir	☐ 100 mg	Other: ____________	______	______
☐ Truvada	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg	Other: ____________	______	______
☐ Viread	☐ 100/150 mg ☐ 133/200 mg ☐ 250 mg ☐ 300 mg	Other: ____________	______	______
☐ Abacavir **Brand no longer available for this drug*	☐ 300 mg	Other: ____________	______	______
☐ Zidovudine	☐ 100 mg ☐ 300 mg	Other: ____________	______	______
NNRTIs:				
☐ Edurant	☐ 25 mg	Other: ____________	______	______
☐ Efavirenz	☐ 600 mg	Other: ____________	______	______
☐ Intelence	☐ 25 mg ☐ 100 mg ☐ 200 mg	Other: ____________	______	______
☐ Pifeltro	☐ 100mg	Other: ____________	______	______
☐ Sustiva	☐ 50 mg ☐ 200 mg	Other: ____________	______	______

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: ____________ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** ____________
Address: ____________ **City/State/ZIp:** ____________
Phone: ____________ **Fax:** ____________ **Contact Person:** ____________

☐ DISPENSE AS WRITTEN ☐ BRAND MEDICALLY NECESSARY ☐ DO NOT SUBSTITUTE ☐ NO SUBSTITUTION / ☐ DAW / ☐ MAY NOT SUBSTITUTE	☐ May Substitute / ☐ Product Selection Permitted / ☐ Substitution Permissible
Prescriber's Signature: ____________ Date: ____________	Prescriber's Signature: ____________ Date: ____________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to info@ivsolutionsrx.com and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE #welcome to our family

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Patient Clinical Information: Drug Allergies:______________________ ☐ NKDA **Ht:** __________in/cm **Wt:** __________lbs/Kg

CD4 Count: ________ **Baseline Viral load:** ________ *Date of labs:* _____/_____/_____

Coinfection: ☐None ☐HCV ☐HBV **HLA-B*5701 test:** ☐Negative Positive

4 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
INTEGRASE INHIBITORS:				
☐ Isentress	☐ 400 mg	Other: ______	______	______
☐ Isentress HD	☐ 600 mg	Other: ______	______	______
☐ Tivicay	☐ 50 mg	Other: ______	______	______
☐ Tivicay PD	☐ 5 mg	Other: ______	______	______
ENTRY INHIBITORS:				
☐ Selzentry	☐ 150 mg ☐ 300 mg	Other: ______	______	______
PROTEASE INHIBITORS:				
☐ Aptivus	☐ 250 mg ☐ 100 mg/mL	Other: ______	______	______
☐ Evotaz	☐ 300/150 mg	Other: ______	______	______
☐ Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL	Other: ______	______	______
☐ Fosamprenavir **Brand no longer available for this drug*	☐ 700 mg	Other: ______	______	______
☐ Norvir	☐ 100 mg ☐ 80 mg/mL	Other: ______	______	______
☐ Prezcobix	☐ 800/150 mg	Other: ______	______	______
☐ Prezista	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg	Other: ______	______	______
☐ Reyataz	☐ 150 mg ☐ 200 mg ☐ 300 mg	Other: ______	______	______
☐ Viramune	☐ 250 mg ☐ 625 mg	Other: ______	______	______
ATTACHMENT INHIBITORS:				
☐ Rukobia	☐ 600 mg Extended-Release	Other: ______	______	______
PHARMACOKINETIC ENHANCER:				
☐ Tybost	☐ 150 mg	Other: ______	______	______
OTHER:				
Other: ______	Other: ______	Other: ______	______	______
Other: ______	Other: ______	Other: ______	______	______
Other: ______	Other: ______	Other: ______	______	______

5 PRESCRIBER SIGNATURE REQUIRED ***(STAMP SIGNATURE NOT ALLOWED)***

Prescriber Name: ______________________ **Title:** ☐MD ☐DO ☐ND ☐PA ☐APRN **NPI:** ____________
Address: ______________________ **City/State/ZIp:** ______________________
Phone: ____________ **Fax:** ____________ **Contact Person:** ____________

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