

Add Logo

E-prescribe the *Fast & Easy* way: select
(Add company name) from your EHR!

HIV Referral Form

Fax: (000) 000-0000
Phone: (000) 000-0000

PATIENT INFORMATION

Patient Name:	SSN:	DOB:
Address:	City:	State: Zip:
Home Phone:	Height:	Weight: Gender: Male Female
Cell Phone:	Email Address:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION

Diagnosis: _____ ICD- 10: _____ Serum Creatinine: _____
 CD4 Count: _____ Viral Load: _____ Date of Labs: _____
 Treatment Naïve Treatment Experienced Prior Treatment Type: _____
 Comorbidities: _____ Allergies NKDA Other _____

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
ATRIPLA® (efavirenz, emtricitabine, tenofovir disoproxil fumarate)	600/ 300/ 200 mg tablet	One tablet by mouth QD on an empty stomach	30 tabs		PREZISTA® (darunavir)	<input type="checkbox"/> 75 mg tablet <input type="checkbox"/> 150 mg tablet <input type="checkbox"/> 600 mg tablet <input type="checkbox"/> 800 mg tablet <input type="checkbox"/> 100 mg/mL spension	Take _____ x daily	1 month supply	
BIKTARVY® (bictegravir, emtricitabine, tenofovir alafenamide)	50 mg/ 200 mg/ 25 mg	One tablet by mouth QD			RUKOBIA® (fostemsavir)	60 mg tablet	One tablet by mouth BID		
COMBIVIR (lamivudine, zidovudine)	50 mg/ 300 mg	One tablet by mouth BID	60 tabs		REYATAZ® (atazanavir sulfate)	<input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg	Take _____ tabs x daily	1 month supply	
COMPLERA® (emtricitabine, tenofovir alafenamide)	20 mg/25 mg/ 300 mg	One tablet by mouth QD	1 month supply		SELZENTRY® (maraviroc)	_____ mg tablet	Take _____ tabs x daily	1 month supply	
DESCOVID® (emtricitabine, tenofovir alafenamide)	200 mg/ 25 mg	One capsule by mouth QD			STRIBILD® (elvitegravir, cobicistat, emtricitabine, tenofovir disoproxil fumarate)	150/ 150/ 200/ 300 mg tablet	One tablet by mouth QD with food	1 month supply	
EDURANTA® (rilpivirine)	25 mg tabs	Take _____ tabs by mouth QD with food			SUSTIVA® (efavirenz)	<input type="checkbox"/> 600 mg tablet	Take one tablet at bedtime	30 tablets	
EMTRIVA® (emtricitabine)	200 mg caps	One tablet by mouth QD	30 capsules		TIVICAY® (dolutegravir)	50 mg tablet	Take _____ tabs x daily	1 month supply	
EPIVIR (lamivudine)	<input type="checkbox"/> 150 mg caps <input type="checkbox"/> 300 mg caps	One capsule _____ x daily	1 month supply		TRIUQUEQ® (abacavir, dolutegravir, lamivudine)	50/600/300 tablet	One tablet by mouth QD with or without food	30 tablets	
EPZICOM® (abacavir, lamivudine)	600 mg/ 300 mg tablet	One tablet by mouth QD	1 month supply		TRIZIVIR® (abacavir, lamivudine, zidovudine)	300/150/300 mg tablet	One tablet by mouth BID	60 tablets	
EVOTAZ™ (atazanavir, cobicistat)	300 mg/150 mg tablet	One tablet by mouth QD with food	30 tabs		TROGARZO™ (ibalizumab-uiyk)	150 mg/ ml	<input type="checkbox"/> Induction Dose: 2000 mg IV dose per 250 ml Sodium Chloride 0.9% <input type="checkbox"/> Maintenance Dose: 800 mg IV per 250 ml Sodium Chloride 0.9% every 14 days		
FUZEON® (enfuvirtide)	108 mg/vial	Inject 90 mg SQ 2 x daily	1 kit		TRUVADA® (emtricitabine and tenofovir disoproxil fumarate)	200/ 300 mg tablet	One tablet by mouth QD with or without food		
GENVOYA® (elvitegravir, cobicistat, emtricitabine, tenofovir alafenamide)	150/150/200/10 tablet	One tablet by mouth QD with food	30 tabs		VIRACEPT® (nefinavir mesylate)	<input type="checkbox"/> 250 mg <input type="checkbox"/> 625 mg	Take _____ tabs 3 x daily		
INTELENCE® (etravirine)	200 mg tablet	One tablet by mouth BID	1 month supply		VIRAMUNE XR® (nevirapine)	400 mg tab	One tablet by mouth QD		
ISENTRESS® (raltegravir)	400 mg tablet	One tablet by mouth 2 x daily	60 tabs		VIREAD® (tenofovir disoproxil fumarate)	300 mg tabs	Take _____ tabs daily		
KALETRA® (lopinavir/ritonavir)	200/ 50 mg tablet	Take _____ tablet x daily	120 tabs		ZERIT® (stavudine)	<input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 40 mg	Take _____ tabs BID		
LEXIVA® (fosamprenavir calcium)	700 mg tablet	Take _____ tablet x daily	1 month supply		OTHER				
NORVIR® (ritonavir)	100 mg tablet	Take _____ tablet x daily	1 month supply		OTHER				
ODEFSEY® (emtricitabine, rilpivirine, and tenofovir alafenamide)	200/25/25 mg tablet	One tablet by mouth QD with food	30 tabs		OTHER				
PIFELTRO™ (doravirine)	100 mg tablet	One tablet by mouth QD with food	30 tablets						
PREZCOBIX® (darunavir and cobicistat)	800/150 mg tablet	One tablet by mouth QD	30 tablets						

Start of Therapy Date:

Special Delivery Instructions:

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

Your signature authorizes (add company name) Pharmacy Services, LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients. ©2023 CarepathRx. All rights reserved.