AcariaHealth
An envolve Pharmacy Solution

Phone: 833.626.8417 • Fax: 833.620.2725

Date Shipment Needed: ____________ Ship To: ❑Patient ❑Prescriber
❑Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

HIV REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight: ❑lbs. ❑kg.
SSN:	Phone:	Allergies:		
Address:		City:	State:	Zip:
Emergency Contact:		Phone:	❑**Please attach demographic information**	

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑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)

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): ____________________
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): ____________________
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: ____________________
- How long should patient wait before starting the new medication? ____________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): ____________________

PRESCRIPTION INFORMATION

Medication	Strength	Directions	QTY	Refills
NRTIs				
❑Emtriva	200 mg		QTY:_____	Refills:_____
❑Epivir	❑100 mg ❑150 mg ❑300 mg		QTY:_____	Refills:_____
❑Ziagen	❑300 mg ❑4800 mg/240 mL		QTY:_____	Refills:_____
NNRTIs				
❑Edurant	25 mg	1 tab po daily	QTY: 30	Refills:_____
❑Intelence	❑100 mg ❑200 mg		QTY:_____	Refills:_____
❑Pifeltro	100 mg	1 tab po daily	QTY: 30	Refills:_____
❑Sustiva	❑200 mg ❑600 mg		QTY:_____	Refills:_____
Combination Antiretrovirals				
❑Atripla	600 mg/200 mg/300 mg	1 tab po daily on empty stomach (CrCl >50 mL/min)	QTY: 30	Refills:_____
❑Biktarvy	50 mg/200 mg/25 mg	1 tab po daily	QTY: 30	Refills:_____
❑Complera	200 mg/25 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills:_____
❑Delstrigo	100 mg/300 mg/300 mg	1 tab po daily	QTY: 30	Refills:_____
❑Dovato	50 mg/300 mg	1 tab po daily (CrCL > 50 mL/min)	QTY: 30	Refills:_____
❑Epzicom	600 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills:_____
❑Genvoya	150 mg/150 mg/200 mg/10 mg	1 tab po daily (CrCl >30 mL/min)	QTY: 30	Refills:_____
❑Juluca	50 mg/25 mg	1 tab po daily	QTY: 30	Refills:_____
❑Odefsey	25 mg/200 mg	1 tab po daily	QTY: 30	Refills:_____
❑Stribild	150 mg/150 mg/200 mg/300 mg	1 tab po daily (CrCl >70 mL/min)	QTY: 30	Refills:_____
❑Symfi	600 mg/300 mg/300 mg	1 tab po daily	QTY: 30	Refills:_____
❑Symfi Lo	400 mg/300 mg/300 mg	1 tab po daily (preferably at bedtime)	QTY: 30	Refills:_____
❑Symtuza	800 mg/150 mg/200 mg/10 mg	1 tab po daily	QTY: 30	Refills:_____
❑Triumeq	600 mg/50 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: 30	Refills:_____
❑Truvada	200 mg/300 mg	❑1 tab po daily (CrCl >50 mL/min) ❑1 tab po every 48 hours (CrCl 30-49 mL/min)	QTY: 30 QTY: 15	Refills:_____ Refills:_____
Pharmacokinetic Enhancer				
❑Norvir	100 mg	❑1 tab po daily with food ❑2 tab po daily with food	QTY: 30 QTY: 60	Refills:_____
❑Tybost	150 mg	1 tab po daily with food	QTY: 30	Refills:_____

Prescriber's Signature: ______________________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. Prescriber authorizes AcariaHealth to forward this prescription to another pharmacy, if needed.

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HIV REFERRAL FORM

PATIENT INFORMATION	
Patient Name:	DOB:
INSURANCE INFORMATION	
❑**Please attach front and back of patient's insurance card (medical and prescription)**	
COPAY CARD ENROLLMENT	
❑**Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

Medication	Strength	Direction	QTY	Refills
Integrase Inhibitors/CCR5 Inhibitors				
❑Isentress	❑25 mg ❑100 mg ❑400 mg		QTY:_____	Refills:_____
❑Isentress HD	600 mg	2 tabs po daily	QTY:__60__	Refills:_____
❑Tivicay	❑50 mg		QTY:_____	Refills:_____
Fusion Inhibitors				
❑Fuzeon	90 mg	90 mg sq twice daily (CrCl > 35 mL/min)	QTY:_____	Refills:_____
Protease Inhibitors				
❑Prezista	❑150 mg ❑60 mg ❑800 mg ❑100 mg/mL		QTY:_____	Refills:_____
❑Reyataz	❑200 mg ❑300 mg		QTY:_____	Refills:_____
Boosted Protease Inhibitors				
❑Evotaz	300 mg/150 mg		QTY:_____	Refills:_____
❑Prezcobix	800 mg/150 mg		QTY:_____	Refills:_____
Fusion/Attachment Inhibitors (Others)				
❑Rukobia	600 mg	1 tab po twice daily	QTY:__30__	Refills:_____
❑Selzentry	❑150 mg ❑300 mg	2 tab po twice daily	QTY:__120__	Refills:_____
Other				
❑Egrifta SV	2 mg	Inject 1.4 mg SQ once daily	QTY:__30__	Refills:_____
			QTY:_____	Refills:_____

Prescriber's Signature: ____ ❑ DAW (Dispense as Written) **Date: ______________**

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