



HIV Referral Form

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 Phone: 844-414-5805
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Ship to: Patient Prescriber Pick Up (location): _____ Date Needed: _____ Need Nurse Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: _____ DEA#: _____
City: _____ State: _____ Zip: _____	Address: _____
Phone: () _____ Alt Phone: () _____	City: _____ State: _____ Zip: _____
Emergency Contact Name:	Phone: () _____ Fax: () _____
Emergency Contact Phone: () _____	Nurse/Key Office Contact: _____
Patient Soc. Sec#: _____ Date of Birth: / /	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight _____ lbs/kg Height _____	
Allergies:	

CLINICAL INFORMATION (Please FAX recent clinical notes, labs, tests & current medication list with prescription)

Diagnosis <input type="checkbox"/> B20 HIV/AIDS <input type="checkbox"/> B18.2 Hepatitis C (Chronic) <input type="checkbox"/> B19.10 Hepatitis B (Chronic) <input type="checkbox"/> Other _____ Labs (please include copy of most recent labs) CD4 count: _____ Viral Load/HIV RNA: _____ Hgb/Hct: _____ WBC/ANC: _____ CrCl: _____ Pregnancy (if appropriate): _____ Date: _____	Treatment History Has the patient been previously treated for HIV and relapsed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the medications previously used: _____ Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the current treatment: _____ Will any of the above medications be discontinued when patient starts new therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list meds to be discontinued: _____ Does patient have any contraindications or intolerances to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name medication and describe reaction? _____
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PRESCRIPTION INFORMATION									
DRUG	STRENGTH	DIRECTIONS	QTY	REFILL	DRUG	STRENGTH	DIRECTIONS	QTY	REFILL
NRTIs					NNRTIs				
<input type="checkbox"/> Videx EC	<input type="checkbox"/> 250 <input type="checkbox"/> 400	_____mg _____Time(s)/day			<input type="checkbox"/> Intelence	<input type="checkbox"/> 100 <input type="checkbox"/> 200	_____mg _____Time(s)/day		
<input type="checkbox"/> Epivir	<input type="checkbox"/> 150 <input type="checkbox"/> 300	_____mg _____Time(s)/day			<input type="checkbox"/> Rescriptor	<input type="checkbox"/> 400	_____mg _____Time(s)/day		
<input type="checkbox"/> Retrovir	<input type="checkbox"/> 100 <input type="checkbox"/> 50mg/5mL	_____mg _____Time(s)/day			<input type="checkbox"/> Sustiva	<input type="checkbox"/> 200 <input type="checkbox"/> 600	_____mg _____Time(s)/day		
<input type="checkbox"/> Viread	<input type="checkbox"/> 150 <input type="checkbox"/> 300	_____mg _____Time(s)/day			<input type="checkbox"/> Viramune	<input type="checkbox"/> 200 <input type="checkbox"/> 400XR <input type="checkbox"/> 50mg/5mL	_____mg _____Time(s)/day		
<input type="checkbox"/> Zerit	<input type="checkbox"/> 30 <input type="checkbox"/> 40	_____mg _____Time(s)/day			<input type="checkbox"/> Edurant	<input type="checkbox"/> 25	_____mg _____Time(s)/day		
<input type="checkbox"/> Emtriva	<input type="checkbox"/> 200	_____mg _____Time(s)/day			Protease Inhibitors				
<input type="checkbox"/> Ziagen	<input type="checkbox"/> 300 <input type="checkbox"/> 480mg/240mL	_____mg _____Time(s)/day			<input type="checkbox"/> Prezista	<input type="checkbox"/> 150 <input type="checkbox"/> 600 <input type="checkbox"/> 800 <input type="checkbox"/> 100mg/mL	_____mg _____Time(s)/day		
<input type="checkbox"/> Descovy	<input type="checkbox"/> 200/25	1 tab po daily with or without food			<input type="checkbox"/> Crixivan	<input type="checkbox"/> 200 <input type="checkbox"/> 400	_____mg _____Time(s)/day		
Combination Antiretrovirals					<input type="checkbox"/> Invirase	<input type="checkbox"/> 200 <input type="checkbox"/> 500	_____mg _____Time(s)/day		
<input type="checkbox"/> Atripla	<input type="checkbox"/> 600/200/300	1 tab po daily on empty stomach			<input type="checkbox"/> Lexiva	<input type="checkbox"/> 700	_____mg _____Time(s)/day		
<input type="checkbox"/> Combivir	<input type="checkbox"/> 150/300	1 tab po BID (CrCl > 50ml/min)			<input type="checkbox"/> Norvir	<input type="checkbox"/> 100 <input type="checkbox"/> 80mg/mL	_____mg _____Time(s)/day		
<input type="checkbox"/> Complera	<input type="checkbox"/> 200/25/300	1 tab po Daily			<input type="checkbox"/> Aptivus	<input type="checkbox"/> 250 <input type="checkbox"/> 100mg/mL	_____mg _____Time(s)/day		
<input type="checkbox"/> Epzicom	<input type="checkbox"/> 600/300	1 tab po Daily (CrCl > 50ml/min)			<input type="checkbox"/> Reyataz	<input type="checkbox"/> 200 <input type="checkbox"/> 300	_____mg _____Time(s)/day		
<input type="checkbox"/> Kaletra	<input type="checkbox"/> 100/25 <input type="checkbox"/> 200/50	_____mg _____Time(s)/day			<input type="checkbox"/> Viracept	<input type="checkbox"/> 250 <input type="checkbox"/> 625	_____mg _____Time(s)/day		
<input type="checkbox"/> Odefsey	<input type="checkbox"/> 200/25/25	1 tab po daily with food			Integrase Inhibitors/CCR5 Inhibitors				
<input type="checkbox"/> Stribild	<input type="checkbox"/> 150/150/200/300	1 tab po Daily (CrCl>70ml/min)			<input type="checkbox"/> Isentress	<input type="checkbox"/> 25 <input type="checkbox"/> 100 <input type="checkbox"/> 400	_____mg _____Time(s)/day		
<input type="checkbox"/> Trizivir	<input type="checkbox"/> 300/150/300	1 tab po BID (CrCl > 50ml/min)			<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 <input type="checkbox"/> 300	_____mg _____Time(s)/day		
<input type="checkbox"/> Triumeq	<input type="checkbox"/> 600/50/300	1 tab po Daily			<input type="checkbox"/> Tivicay	<input type="checkbox"/> 50	_____mg _____Time(s)/day		
<input type="checkbox"/> Truvada	<input type="checkbox"/> 200/300	<input type="checkbox"/> 1 tab po Daily (CrCl > 50ml/min) <input type="checkbox"/> 1 tab po Q48h (CrCl 30-49ml/min)			<input type="checkbox"/> Vitekta	<input type="checkbox"/> 85 <input type="checkbox"/> 150	_____mg _____Time(s)/day		
<input type="checkbox"/> Evotaz	<input type="checkbox"/> 300/150	_____mg _____Time(s)/day			Other				
<input type="checkbox"/> Prezobix	<input type="checkbox"/> 800/150	_____mg _____Time(s)/day			<input type="checkbox"/> Tybost	<input type="checkbox"/> 150	<input type="checkbox"/> 1 tab po daily with food		
<input type="checkbox"/> Genvoya	<input type="checkbox"/> 150/150//200/10	1 tab po Daily (CrCl > 30ml/min)			<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
Fusion Inhibitor					<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		
<input type="checkbox"/> Fuzeon	<input type="checkbox"/> 90	90mg SQ BID (CrCl > 35ml/min)			<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.

Date: _____

DISPENSE AS WRITTEN

MAY SUBSTITUTE