HIV REFERRAL FORM

EL NORTE Retail & Specialty Pharmacy

Phone: (760) 233-2100
Fax: (760-233-2105

Ship To: ❑ Patient ❑ Physician / Clinic ❑ Pick Up ❑ Date Needed: _____ **Injection Training Needed:** ❑ Yes ❑ No

PATIENT INFORMATION					PRESCRIBER INFORMATION	
	Patient Name				**Prescriber Name**	
	Address				**NPI**	
	City, State, Zip				**Address**	
	Primary Phone		**Alt. Phone**		**City, State, Zip**	
	Date of Birth		**Allergies**		**Office Phone:**	
	Height/ Weight		**Sex:**	❑ Male ❑ Female	**Office Fax:**	
	Insurance	**PLEASE FAX A COPY OF INSURANCE CARD(S)**			**Contact Person**	

CLINICAL INFORMATION

Diagnosis: ❑ HIV ❑ Hepatitis B ❑ Hepatitis C ICD10 Code: _____ ❑ Other: _____

PRESCRIPTION INFORMATION

NRTIs

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **EMTRIVA**	❑ 200 mg			
❑ **EPIVIR**	❑ 150 mg ❑ 300 mg			
❑ **RETROVIR**	❑ 100 mg ❑ 300 mg			
❑ **VIDEX EC**	❑ 125 mg ❑ 200 mg ❑ 250 mg ❑ 400 mg			
❑ **VIREAD**	❑ 150 mg ❑ 200 mg ❑ 25 0mg ❑ 300 mg			
❑ **ZERIT**	❑ 15 mg ❑ 20 mg ❑ 30 mg ❑ 40 mg			
❑ **ZIAGEN**	❑ 300 mg			

NNRTs

❑ **EDURANT**	❑ 25 mg			
❑ **INTELENCE**	❑ 25 mg ❑ 100 mg ❑ 200 mg			
❑ **RESCRIPTOR**	❑ 100 mg ❑ 200 mg			
❑ **SUSTIVA**	❑ 50 mg ❑ 200 mg ❑ 600 mg			
❑ **VIRAMUNE XR**	❑ 100 mg ❑ 400 mg			

COMBINATION ANTIRETROVIRALS

❑ **ATRIPLA**	600/200/300			
❑ **COMBIVIR**	150/300			
❑ **COMPLERA**	200/25/300			
❑ **DESCOVY**	200/25			
❑ **EPZICOM**	600/300			
❑ **GENVOYA**	150/200/150/10			
❑ **ODEFSEY**	200/25/25			
❑ **PREZCOBIX**	800/150			

PROTEASE INHIBITORS (PIs)

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑ **APTIVUS**	❑ 250 mg			
❑ **CRIXIVAN**	❑ 200 mg ❑ 400 mg			
❑ **EVOTAZ**	❑ 300/150 mg			
❑ **INVIRASE**	❑ 200 mg ❑ 500 mg			
❑ **KALETRA**	❑ 200/50 mg ❑ 100/25 mg			
❑ **LEXIVA**	❑ 700 mg			
❑ **NORVIR**	❑ 100 mg			
❑ **PREZISTA**	❑ 75 mg ❑ 150 mg ❑ 600 mg ❑ 800 mg			
❑ **REYATAZ**	❑ 150 mg ❑ 200 mg ❑ 300 mg			
❑ **VIRACEPT**	❑ 250 mg ❑ 625 mg			

ENTRY INHIBITORS

❑ **FUZEON**	❑ 90 mg VIAL			
❑ **SELZENTRY**	❑ 150 mg ❑ 300 mg			

INTEGRASE INHIBITORS

❑ **ISENTRESS**	❑ 400 mg ❑ 600 mg			
❑ **TIVICAY**	❑ 50 mg			

COMBINATION ANTIRETROVIRALS (continued)

❑ **STRIBILD**	150/150/200/300			
❑ **TRIUMEQ**	600/50/300			
❑ **TRIZIVIR**	300/150/300			
❑ **TRUVADA**	200/300			
❑ **OTHER**				

By signing below, I authorize El Norte Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and help the patient to apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ Date: _____