TruCare PHARMACY

Phone: 951-817-1005 | **Fax: 951-817-1020**

HIV / AIDS REFERRAL FORM

☐ All supplies including Syringes and needles will be dispensed if needed.

Ship To: ☐ Patient ☐ Physician ☐ Nursing Needs ☐ Training needed

Patient Name (Required):	Physician Name:
Home Phone: ( ) Work Phone: ( )	LIC#: DEA #:
Cell Phone: ( )	NPI #: Specialty:
Emergency Contact Name: (Required):	Practice Name/Hospital:
Emergency Contact Phone #: (Required):	Address:
Patient Soc. Sec #: Allergies:	City: State: Zip:
DOB (Required): Sex: ☐ M ☐ Weight: ☐ lbs. ☐ Kg	Physician's Phone: ( )
Patient Ethnicity:	Physician's Fax: ( )
☐ **See attached demographic sheet** Height: BSA: m²	Nurse/Key Office Contact:

INSURANCE INFORMATION (Complete or Attach copies of cards)

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	BIN:	Last Name:
Plan #:	Plan #:	City: State:	:
Group #:	Group #:	p #:	ID#
Phone: ( )	Phone: ( )	Phone: ( )	Group #:

DIAGNOSIS INFORMATION

☐ 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)

MEDICAL NECESSITY

Has patient previously been on therapy? ☐ Yes ☐ No List of previous meds _____

Is patient currently on therapy? ☐ Yes ☐ No List of previous meds _____

Will any of the above medications be discontinued when patient starts on the new therapy? ☐Yes ☐No List of previous meds _____

(Note: Fuzeon must be taken as part of a combination antiviral regimen)

Is patient currently taking any other medications? ☐ Yes ☐ No List of medications _____

Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____

PRESCRIPTION INFORMATION (one month supply will be dispensed unless quantity is indicated)

Medication	Strength (mg)	Directions	QTY	Refill
NRTIs				
☐ **Emtriva**	☐200	_____Caps _____ Time(s)/day		
☐ **Epivir**	☐150 ☐300	_____Tabs _____ Time(s)/day		
☐ **Retrovir**	☐100 ☐50mg/5ml	_____Caps _____ Time(s)/day _____mLs _____ Time(s)/day		
☐ **Viread**	☐150 ☐300	_____Tabs _____ Time(s)/day		
☐ **Zerit**	☐30 ☐40	_____Caps _____ Time(s)/day		
☐ **Ziagen**	☐300 ☐480mg/240mL	_____Tabs _____ Time(s)/day _____mLs _____ Time(s)/day		
NNRTIs				
☐ **Intelence**	☐ 100 ☐ 200	_____Tabs _____ Time(s)/day		
☐ **Rescriptor**	☐ 400	_____Tabs _____ Time(s)/day		
☐ **Sustiva**	☐ 200 ☐ 600	_____Caps _____ Tabs_____Time(s)/day		
☐ **Viramune**	☐ 200 ☐ 400XR ☐ 50mg/5ml	_____Tabs _____ Time(s)/day _____mLs _____ Time(s)/day		
COMBINATION ANTIRETROVIRALS				
☐ **Atripla**	600/200/300	1 tab po Daily on empty stomach	30	
☐ **Combivir**	150/300	1 tab po BID (CrCl>50ml/min)	60	
☐ **Complera**	200/25/300	1 tab po Daily (CrCl>50ml/min)	30	
☐ **Epzicom**	600/300	1 tab po Daily (CrCl>50ml/min)	30	
☐ **Genvoya**	150/150/200/10	1 tab po Daily (CrCl>30ml/min)	30	
☐ **Kaletra**	☐100/25 ☐200/50	_____Tabs _____ Time(s)/day		
☐ **Stribild**	150/150/200/300	1 tab po Daily (CrCl>70ml/min)	30	
☐ **Trizivir**	300/150/300	1 tab po BID (CrCl>50ml/min)	60	
☐ **Triumeq**	600/50/300	☐ 1 tab po Daily (CrCl>50ml/min)	30	
☐ **Truvada**	200/300	☐ 1 tab po Daily (CrCl>50ml/min) ☐ 1 tab po Q48hr (CrCl 30-49ml/min)	30 15	
☐ **Odefesy**	200/25/25	_____Tabs _____ Time(s)/day		

Medication	Strength (mg)	Directions	QTY	Refill
PROTEASE INHIBITORS				
☐ **Aptivus**	☐250 ☐100mg/mL	_____Caps _____ Time(s)/day _____mLs _____ Time(s)/day		
☐ **Crixivan**	☐200 ☐400	_____Caps _____ Time(s)/day		
☐ **Invirase**	☐200 ☐500	_____Caps _____ Time(s)/day _____Tabs _____ Time(s)/day		
☐ **Lexiva**	☐700	_____Tabs _____ Time(s)/day		
☐ **Norvir**	☐100 ☐80mg/mL	_____Caps _____ Tabs_____Time(s)/day _____mLs _____ Time(s)/day		
☐ **Prezista**	☐150 ☐600 ☐800 ☐100mg/mL	_____Tabs _____ Time(s)/day _____mLs _____ Time(s)/day		
☐ **Reyataz**	☐200 ☐300	_____Caps _____ Time(s)/day		
☐ **Viracept**	☐250 ☐625	_____Tabs _____ Time(s)/day		
INTEGRASE INHIBITORS / CCR5 INHIBITORS				
☐ **Isentress**	☐25 ☐100 ☐400	_____Tabs _____ Time(s)/day		
☐ **Selzentry**	☐150 ☐300	_____Tabs _____ Time(s)/day		
☐ **Tivicay**	☐50	_____Tabs _____ Time(s)/day		
☐ **Vitekta**	☐85 ☐150	_____Tabs _____ Time(s)/day w food		
BOOSTED PROTEASE INHIBITORS				
☐ **Evotaz**	300/150	_____Tabs _____ Time(s)/day w food		
☐ **Prezcobix**	800/150	_____Tabs _____ Time(s)/day		
N(t)RTIs				
☐ **Edurant**	25	_____Tabs _____ Time(s)/day		
☐ **Emtriva**	200	_____Caps _____ Time(s)/day		
☐ **Videx EC**	☐ 250 ☐ 400	_____Caps _____ Time(s)/day		
FUSION INHIBITORS				
☐ **Fuzeon**	90	90mg SQBID (CrCl > 35ml/min)		
PHARMACOKINETIC ENHANCER				
☐ **Tybost**	150	1 tab po Daily with food	30	

☐ **Other** _____Caps _____ Tabs_____Time(s)/day **Qty:** **Refill:** **# of Medications Prescribed:** _____

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice. tcv101816