STAR CARE PHARMACY

"The First Wealth is Health"

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HIV/AIDS REFERRAL FORM

Date: _____ Attn: _____

Ship to ❒ Patient ❒ Physician Office ❒ Nurse/Training

Patient Name _____

Address _____ Suite# _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Cell _____ Email _____

Date of Birth _____ SS# _____

☐ Male ☐ Female Weight _____ Height _____

Prescriber's Name _____

License# _____ DEA# _____

NPI# _____ UPIN# _____

Practice Name _____

Office Contact _____

Address _____ Suite# _____

City _____ State _____ Zip _____

Tel _____ Fax _____

Insurance Information *(Complete or attach copies of cards)*

Primary Insurance: _____

ID#: _____

Group #: _____

Insured's Name: _____

City: _____ State: _____ Phone: ( ) _____ - _____

Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis Code: ☐ 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 on therapy and relapsed? ☐ Yes ☐ No List of medication(s) _____

Is patient currently on therapy? ☐ Yes ☐ No List of medication(s) _____

Will patient stop taking the medication(s) before or when starting the new medication? ☐ Yes ☐ No

List of medication(s) to be discontinued (Note: Fuzeon must be taken as part of a combination antiviral regimen)_____

Current medications patient (including OTC) with dosage and direction (or fax medication) _____

Prescription

NRTI's

DESCOVY 200/25mg
Tabs #____ Refill x _____ Sig _____

EMTRIVA 200mg
Caps #____ Refill x _____ Sig _____

EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol #____ Refill x _____ Sig _____

RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol #____ Refill x _____ Sig _____

VIDEX EC 125mg 200mg 250mg 400mg
Plain Videx Solution 10mg/ml
Tabs | Pwd #____ Refill x ____ Sig _____

VIREAD 300mg
Tabs | Sol #____ Refill x ____ Sig _____

ZERIT
15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol #____ Refill x ____ Sig _____

ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs | Sol #____ Refill x ____ Sig _____

OTHER MEDICATIONS

☐ **BACTRIM**
☐ **ISENTRESS** 400mg
☐ **MEGACE** 40mg/ml
☐ **MEGACE ES** 625mg/5ml
☐ **SELZENTRY**
☐ **EGRIFTA** 2 mg (2x1mg)
SIG: 2 mg SQ daily QTY: 60 Vials
SIG _____ QTY____ Refill_____

☐ **DIFLUCAN**
☐ **NEUPOGEN**
☐ **PROCRIT**
☐ **STRIBILD**
☐ **VALCYTE**
☐ **VISTIDE**

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs #_____ Refill x _____ Sig _____

INTELENCE 100 mg 200mg
Tabs #_____ Refill x _____ Sig _____

RESCRIPTOR 200mg
Caps #_____ Refill x _____ Sig _____

SUSTIVA 50mg 200mg 600mg
Tabs | Caps #_____ Refill x _____ Sig _____

VIRAMUNE 200mg 50mg/5ml
Tabs | Sol #____ Refill x _____ Sig _____

COMBINATION ANTIRETROVIRALS

ATRIPLA 600/200/3000mg
Tabs #____ Refill x____ Sig _____

COMBIVIR 150/300mg
Tabs | Sol #____ Refill x _____ Sig _____

COMPLERA
Tabs | Sol #____ Refill x _____ Sig _____

EPZICOM 600/300mg
Tabs #____ Refill x ____Sig _____

ODEFSEY 200/300mg
Tabs #____ Refill x ____Sig _____

TRIZIVIR 300/150/300mg
Tabs | Sol #____ Refill x _____ Sig _____

TRUVADA 200/300mg
Tabs | Sol #____ Refill x ____Sig _____

HGH

SEROSTIM ☐ 4mg ☐ 5mg ☐ 6mg
Refill x ____ Sig _____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps #____ Refill x ____ Sig_____

CRIXIVAN 200mg 333mg 400mg
Caps #____ Refill x ____ Sig_____

EVOTAZ
Caps #____ Refill x ____ Sig_____

INVIRASE 200mg 500mg
Caps | Sol #____ Refill x ____ Sig_____

KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #____ Refill x ____ Sig_____

LEXIVA 700mg Oral Susp. 50mg/ml
Tabs #____ Refill x ____ Sig _____

NORVIR 100mg 80mg/ml
Caps | Sol #____ Refill x ____ Sig _____

PREZCOBIX
Caps #____ Refill x ____ Sig _____

PREZISTA 75mg 150mg 400mg 600mg
Tabs | Sol #____ Refill x ____ Sig _____

REYATAZ 100mg 150mg 200mg 300mg
Caps #____ Refill x ____ Sig _____

VIRACEPT 250mg 625mg
Tabs | Pwd #____ Refill x ____ Sig _____

FUSION INHIBITORS

FUZEON 90mg
Refill x ____ Sig _____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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