

HIV PATIENT REFERRAL FORM

Therapy Start Date: ____/____/____ Ship To: Patient Physician 1st Fill Physician All Orders In-store Pickup

Patient Information: Please attach FRONT and BACK copies of ALL insurance cards.

Patient Name: _____ Date of Birth: ____/____/____ Sex: Male Female
 Social Security #: _____ Primary Phone: (____) _____ - _____ Secondary Phone: (____) _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____

Physician Information:

Physician Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (____) _____ - _____ Fax: (____) _____ - _____ Key Contact: _____

Diagnostic Information: Please attach recent Labs, Tests, and Clinical Notes.

ICD-10: B20 HIV/AIDS B18.0 Hepatitis B B18.2 Hepatitis C(Chronic) R64 Cachexia(HIV Wasting)
 Other(Include ICD-10 Code) : _____
 ♦GFR: _____ ♦HLA-B*5701 Errors: _____
 ♦Height: _____ inch cm ♦Weight: _____ lbs kg ♦Allergies _____

Prescription Information:

SINGLE-TABLET REGIMENS

| DRUG | STRENGTH | DIRECTIONS | QTY | REFILLS | DRUG | STRENGTH | DIRECTIONS | QTY | REFILLS |
|------------------------------------|------------------|------------------------------|-----|---------|-----------------------------------|-------------------|------------------------------|-----|---------|
| <input type="checkbox"/> ATRIPLA | 600/200/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> ODEFSEY | 200/25/25mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> BIKTARVY | 50/200/25mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> STRIBILD | 150/150/200/300mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> COMPLERA | 200/25/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> SYMFI | 600/300/300mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> DELSTRIGO | 100/300/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> SYMFI LO | 400/300/300mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> GENVOYA | 150/150/200/10mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> SYMTUZA | 800/150/200/10mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> JULUCA | 50/25mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> TRIUMEQ | 600/50/300mg | Take 1 tablet by mouth daily | 30 | |

OTHERS

| | | | | | | | | | |
|------------------------------------|-----------|------------------------------|----|--|------------------------------------|-----------|------------------------------|----|--|
| <input type="checkbox"/> CIMDUO | 300/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> PREZISTA | 800mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> COMBIVIR | 150/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> PREZISTA | 600mg | Take 1 tablet by mouth BID | 60 | |
| <input type="checkbox"/> DESCOVY | 200/25mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> REYATAZ | 300mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> EDURANT | 25mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> REYATAZ | 200mg | Take 2 tabs by mouth daily | 60 | |
| <input type="checkbox"/> EPIVIR | 300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> SELZENTRY | 150mg | Take 1 tablet by mouth BID | 60 | |
| <input type="checkbox"/> EPIVIR | 150mg | Take 1 tablet by mouth BID | 60 | | <input type="checkbox"/> SELZENTRY | 300mg | Take 1 tablet by mouth BID | 60 | |
| <input type="checkbox"/> EPZICOM | 600/300mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> SUSTIVA | 600mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> EVOTAZ | 300/150mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> TIVICAY | 50mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> INTELENCE | 200mg | Take 1 tablet by mouth BID | 60 | | <input type="checkbox"/> TRUVADA | 300/200mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> ISENTRESS | 600mg | Take 2 tabs by mouth daily | 60 | | <input type="checkbox"/> VIREAD | 300mg | Take 1 tablet by mouth daily | 30 | |
| <input type="checkbox"/> KALETRA | 200/50mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> ZIAGEN | 300mg | Take 2 tabs by mouth daily | 60 | |
| <input type="checkbox"/> PIFELTRO | 100mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> ZIAGEN | 300mg | Take 1 tablet by mouth BID | 60 | |
| <input type="checkbox"/> NORVIR | 100mg | | | | <input type="checkbox"/> OTHER | | | | |
| <input type="checkbox"/> PREZCOBIX | 800/150mg | Take 1 tablet by mouth daily | 30 | | <input type="checkbox"/> OTHER | | | | |

Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

Rep: _____

Rev.: 11/14/2018

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1517 17th Street NW, Washington DC 20036

Phone: 202-503-2644 | Fax: 202-503-1721

Our PA Team is here to help! Here is our contact information:
Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check the status of **pending PA's**, or if you have any questions

call **Dawn** at ext. 221

or **Nick** at ext. 218

❖ ***Please forward to us any updates you receive from the insurance company regarding approvals or denials***

www.grubbsnw.com

Rep: _____

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