



PALMETTO PHARM
USE AS WRITTEN

Phone: 1-800-275-0139 • Fax: 843-972-9395

Date Shipment Needed: _____ Ship To: Patient Prescriber

Nursing needed; Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

HIV REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____		DOB: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: _____	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN: _____	Phone: _____	Allergies: _____			
Address: _____		City: _____	State: _____	Zip: _____	
Emergency Contact: _____		Phone: _____	<input type="checkbox"/> Please attach demographic information		

PRESCRIBER INFORMATION

Prescriber: _____	NPI: _____	DEA: _____	State Lic: _____
Supervising Physician: _____		Practice Name: _____	
Address: _____		City: _____	State: _____ Zip: _____
Phone: _____	Fax: _____	Key Office Contact: _____	Phone: _____

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: 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 treated *previously* for this condition? Yes No Medication(s): _____
- Is patient *currently* on therapy? Yes No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

PRESCRIPTION INFORMATION

Medication	Strength	Directions	QTY	Refills
NRTIs				
<input type="checkbox"/> Emtriva	200 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Efavir	<input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Ziagen	<input type="checkbox"/> 300 mg <input type="checkbox"/> 4800 mg/240 mL		QTY: _____	Refills: _____
NNRTIs				
<input type="checkbox"/> Efavir	25 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Intelence	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Pifeltro	100 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Sustiva	<input type="checkbox"/> 200 mg <input type="checkbox"/> 600 mg		QTY: _____	Refills: _____
Combination Antiretrovirals				
<input type="checkbox"/> Atripla	600 mg/200 mg/300 mg	1 tab po daily on empty stomach (CrCl >50 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Biktarvy	50 mg/200 mg/25 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Complera	200 mg/25 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Delstrigo	100 mg/300 mg/300 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Dovato	50 mg/300 mg	1 tab po daily (CrCl > 50 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Epzicom	600 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Genvoia	150 mg/150 mg/200 mg/10 mg	1 tab po daily (CrCl >30 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Juluca	50 mg/25 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Odefsey	25 mg/200 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Stribild	150 mg/150 mg/200 mg/300 mg	1 tab po daily (CrCl >70 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Symfi	600 mg/300 mg/300 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Symfi Lo	400 mg/300 mg/300 mg	1 tab po daily (preferably at bedtime)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Symtuza	800 mg/150 mg/200 mg/10 mg	1 tab po daily	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Triumeq	600 mg/50 mg/300 mg	1 tab po daily (CrCl >50 mL/min)	QTY: <u>30</u>	Refills: _____
<input type="checkbox"/> Truvada	200 mg/300 mg	<input type="checkbox"/> 1 tab po daily (CrCl >50 mL/min) <input type="checkbox"/> 1 tab po every 48 hours (CrCl 30-49mL/min)	QTY: <u>30</u> QTY: <u>15</u>	Refills: _____
Pharmacokinetic Enhancer				
<input type="checkbox"/> Norvir	100 mg	<input type="checkbox"/> 1 tab po daily with food <input type="checkbox"/> 2 tab po daily with food	QTY: <u>30</u> QTY: <u>60</u>	Refills: _____
<input type="checkbox"/> Tybost	150 mg	1 tab po daily with food	QTY: <u>30</u>	Refills: _____

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

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

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PATIENT INFORMATION				
Patient Name: _____				DOB: _____
INSURANCE INFORMATION				
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)				
COPAY CARD ENROLLMENT				
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____		
PRESCRIPTION INFORMATION				
Medication	Strength	Direction	QTY	Refills
Integrase Inhibitors/CCR5 Inhibitors				
<input type="checkbox"/> Isentress	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Isentress HD	600 mg	2 tabs po daily	QTY: 60	Refills: _____
<input type="checkbox"/> Tivicay	<input type="checkbox"/> 50 mg		QTY: _____	Refills: _____
Fusion Inhibitors				
<input type="checkbox"/> Fuzeon	90 mg	90 mg sq twice daily (CrCl > 35 mL/min)	QTY: _____	Refills: _____
Protease Inhibitors				
<input type="checkbox"/> Prezista	<input type="checkbox"/> 150 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> 800 mg <input type="checkbox"/> 100 mg/mL		QTY: _____	Refills: _____
<input type="checkbox"/> Reyataz	<input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg		QTY: _____	Refills: _____
Boosted Protease Inhibitors				
<input type="checkbox"/> Evtotaz	300 mg/150 mg		QTY: _____	Refills: _____
<input type="checkbox"/> Prezcobix	800 mg/150 mg		QTY: _____	Refills: _____
Fusion/Attachment Inhibitors (Others)				
<input type="checkbox"/> Rukobia	600 mg	1 tab po twice daily	QTY: 30	Refills: _____
<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg	2 tab po twice daily	QTY: 120	Refills: _____
Other				
<input type="checkbox"/> Egrifta SV	2 mg	Inject 1.4 mg SQ once daily	QTY: 30	Refills: _____
			QTY: _____	Refills: _____

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