HIV REFERRAL FORM

Date: ______________________________

Hometech Advanced Therapies

Fax Referral To: 855-884-9283

Phone: 855-494-3121

Needs by Date: ________________ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Alternate Phone: ______________________________
Date of Birth: ______________ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________
DEA#: ________________ NPI#: ________________
Contact Person: ______________________________

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: ______________________________ ID#: ________________________ Group: ______________
Secondary Insurance: ______________________________ ID#: ________________________ Group: ______________
Prescription Card: ____________ ID#: ______________ BIN: ___________ PCN:__________ Group: ______________

DIAGNOSIS & LABWORK *(Fill in below or attach lab work)*

Primary Diagnosis: ☐ B20 HIV ☐ B24 AIDS **Date of Diagnosis**: ____________ **HIV/Hep-C Co-infection**: ☐ Yes ☐ No ☐ Unknown

CD4 / TCELL Count: ______________________ **HIV RNA**: ______________________ **HGB / HCT**: ______________________

White Blood Cell Count: ___________ **Patient Weight**: ____________ **BMI**: _______ **Allergies**: ____________________________

MEDICATION	DOSE/STRENGTH	QUANTITY	REFILLS
NRTI'S			
☐ Emtriva®	______________	________	_______
☐ Epivir®	______________	________	_______
☐ Retrovir®	______________	________	_______
☐ Videx®	______________	________	_______
☐ Viread®	______________	________	_______
☐ Zerit®	______________	________	_______
☐ Ziagen®	______________	________	_______
NNRTI'S			
☐ Edurant®	______________	________	_______
☐ Intelence®	______________	________	_______
☐ Rescriptor®	______________	________	_______
☐ Sustiva®	______________	________	_______
☐ Viramune®	______________	________	_______
Combo / ARV's			
☐ Atripla®	______________	________	_______
☐ Combivir®	______________	________	_______
☐ Descovy®	______________	________	_______
☐ Epzicom®	______________	________	_______
☐ Genvoya®	______________	________	_______
☐ Odesfey®	______________	________	_______
☐ Triumeq®	______________	________	_______
☐ Trizivir®	______________	________	_______

MEDICATION	DOSE/STRENGTH	QUANTITY	REFILLS
Integrase Inhibitors			
☐ Isentress®	______________	________	_______
☐ Tivicay®	______________	________	_______
☐ Vitekta®	______________	________	_______
Protease Inhibitors			
☐ Aptivus®	______________	________	_______
☐ Crixivan®	______________	________	_______
☐ Evotaz®	______________	________	_______
☐ Invirase®	______________	________	_______
☐ Kaletra®	______________	________	_______
☐ Lexiva®	______________	________	_______
☐ Prezcobix®	______________	________	_______
☐ Prezista®	______________	________	_______
☐ Reyataz®	______________	________	_______
☐ Viracept®	______________	________	_______
Entry Inhibitors			
☐ Fuzeon®	______________	________	_______
☐ Selzentry®	______________	________	_______
Boosting Agents			
☐ Norvir®	______________	________	_______
☐ Tybost®	______________	________	_______

Other/Notes:____
____

Prescriber Signature: ______________________________ DAW (Dispense as Written) Date: ____________

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