

# HIV Prescription Referral Form

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## PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Patient Preferred Language:  English  Spanish  \_\_\_\_\_

## PRESCRIBER INFORMATION

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Office's Preferred Method of Contact:  Phone  Fax  Portal  Email: \_\_\_\_\_  Other: \_\_\_\_\_

## PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis:  HIV1  HIV2  \_\_\_\_\_ ICD 10: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Opportunistic Infection:  No  Yes \_\_\_\_\_ Treated:  No  Yes \_\_\_\_\_  
 Treatment Naive:  No  Yes \_\_\_\_\_ Viral Load: \_\_\_\_\_ CD4 Count: \_\_\_\_\_ HEP B:  No  Yes  
 HLA-B5701 Status:  Positive  Negative Known Resistance or Genetic Mutations:  No  Yes \_\_\_\_\_  
 Previous / Failed Medication: \_\_\_\_\_

## MEDICATION [PLEASE NOTE - THIS IS NOT AN INCLUSIVE LIST, PLEASE WRITE IN DESIRED MEDICATIONS ON THE BOTTOM OF THE FORM]

### SINGLE TABLET REGIMENS

- BIKARVY  COMPLERA  DELSTRIGO  DOVATO  GENVOYA  
 JULUCA  ODEFSEY  STRIBILD  SYMTUZA  TRIUMEQ

### SIG

SIG	QTY	RFLS
<input type="checkbox"/> Take 1 tablet by mouth once daily	30	

### INJECTION

CABENUVA FUZEON

### COMBO TABLET REGIMEN

DESCOVY TRUVADA

### SINGLE INGREDIENT TABLETS

EDURANT LEXIVA PIFELTRO PREZCOBIX PREZISTA  
 RUKOBIA SELZENTRY TIVICAY ISENTRESS ISENTRESS HD

## PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO for First Fill

MEDICATION	STRENGTH	ROA (PO / IV / SC)	SIG	QTY	RFLS

## PRESCRIPTION SIGNATURE

Dispense as Written: \_\_\_\_\_ Substitution Permitted: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Blue Sky Specialty Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer

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