HIV/AIDS Referral Form

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Attention: ____________________ Need By Date: ____________ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name: ____________________ DOB: ____________ Sex: ☐ Male ☐ Female
Address: ____________________ City: ____________ State: ____________ Zip: ________
Home#: ____________ Work #: ____________ Cell#: ____________ Best time to call: ☐ AM ☐ PM
Soc. Sec #: ____________________ Ethnicity: ____________ Primary Language: ____________
Comorbidities: ____________ Height: ________ Weight: ________ Date: ________
Allergies: ________________________________ ☐ NKDA

Provider

Physician Name: ____________ Practice Name: ____________ State Lic#: ________ DEA#: ________
Address: ____________ City: ____________ State: ________ Zip: ________ NPI#: ________
Phone#: ____________ Fax#: ____________ Nurse/Key Office Contact: ____________ Ext.: ________

Insurance

Primary Insurance: ____________ ID: ____________ Phone: ____________
Secondary Insurance: ____________ ID: ____________ Phone: ____________
* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

MULTI-CLASS COMBINATION PRODUCTS

DRUG NAME	DOSE	SIG	QTY	RFLS
Atripla	600/200/300mg tabs	ONE PO QHS ON EMPTY STOMACH		
Complera	200/25/300mg tabs	ONE PO QD WITH FOOD		
Genvoya	150/150/200/10 MG tabs	ONE PO QD WITH FOOD		
Stribild	150/150/200/300mg tabs	ONE PO QD WITH FOOD		
Triumeq	50/300/600mg tabs	ONE PO QD		

NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS(NNRTI's)

DRUG NAME	DOSE	SIG	QTY	RFLS
Edurant	25mg tabs			
Intelence	______mg tabs			
Rescriptor	______mg tabs			
Sustiva	______mg tabs/caps			
Viramune XR	______mg tabs			

NUCLEOSIDE/NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS(NRTI'S)

DRUG NAME	DOSE	SIG	QTY	RFLS
Combivir	150/300mg tabs			
Emtriva	200mg caps			
Epivir	________mg tabs			
Epzicom	600/300mg tabs			
Retrovir	________mg tabs			
Trizivir	300/150/300mg tabs			
Truvada	200/300mg tabs			
Videx EC	________mg caps			
Viread	300mg tabs			
Zerit	________mg caps			
Ziagen	300mg tablets			

PROTEASE INHIBITORS(PI's)

DRUG NAME	DOSE	SIG	QTY	RFLS
Aptivus	250mg caps			
Crixivan	____mg caps			
Evotaz	300/150mg tabs			
Invirase	____mg tabs/caps			
Kaletra	____mg tabs			
Lexiva	700mg tabs			
Prezcobix	800/150mg tabs			
Prezista	____mg tabs			
Reyataz	____mg caps			
Viracept	____mg tabs			

PHARMACOKINETIC ENHANCERS

DRUG NAME	DOSE	SIG	QTY	RFLS
Norvir	100mg tabs			
Norvir	100mg caps			
Tybost	150mg tabs			

ENTRY INHIBITORS/ INTEGRASE INHIBITORS

DRUG NAME	DOSE	SIG	QTY	RFLS
Selzentry	_____mg tabs			
Isentress	400mg tabs			
Tivicay	50mg tabs			
Vitekta	_____mg tabs			

ADDITIONAL MEDICATIONS

DRUG NAME	DOSE	SIG	QTY	RFLS	DRUG NAME	DOSE	SIG	QTY	RFLS

Physicians Signature: ____________________ Date: ____________

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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