Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
1204 SE 28th St, Suite 2
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Phone: 844-414-5805
Fax: 855-422-2400

HIV Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑B20 HIV/AIDS ❑B18.2 Hepatitis C (Chronic)
❑B19.10 Hepatitis B (Chronic) ❑Other _____

Labs *(please include copy of most recent labs)*
CD4 count: _____
Viral Load/HIV RNA:_____
Hgb/Hct:_____
WBC/ANC:_____
CrCl:_____
Pregnancy (if appropriate):_____ Date:_____

Treatment History
Has the patient been previously treated for HIV and relapsed? ❑Yes ❑No
If yes, please list the medications previously used:_____
Is patient currently on therapy? ❑Yes ❑No
If yes, please list the current treatment:_____
Will any of the above medications be discontinued when patient starts new therapy? ❑Yes ❑No
If yes, please list meds to be discontinued:_____
Does patient have any contraindications or intolerances to any medications? ❑Yes ❑No
If yes, please name medication and describe reaction?_____

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QTY	REFILL
NRTIs				
☐ Videx EC	☐ 250 ☐ 400	_____mg _____Time(s)/day		
☐ Epivir	☐ 150 ☐ 300	_____mg _____Time(s)/day		
☐ Retrovir	☐ 100 ☐ 50mg/5mL	_____mg _____Time(s)/day		
☐ Viread	☐ 150 ☐ 300	_____mg _____Time(s)/day		
☐ Zerit	☐ 30 ☐ 40	_____mg _____Time(s)/day		
☐ Emtriva	☐ 200	_____mg _____Time(s)/day		
☐ Ziagen	☐ 300 ☐ 480mg/240mL	_____mg _____Time(s)/day		
☐ Descovy	☐ 200/25	1 tab po daily with or without food		
Combination Antiretrovirals				
☐ Atripla	☐ 600/200/300	1 tab po daily on empty stomach		
☐ Combivir	☐ 150/300	1 tab po BID (CrCl > 50ml/min)		
☐ Complera	☐ 200/25/300	1 tab po Daily		
☐ Epzicom	☐ 600/300	1 tab po Daily (CrCl > 50ml/min)		
☐ Kaletra	☐ 100/25 ☐ 200/50	_____mg _____Time(s)/day		
☐ Odefsey	☐ 200/25/25	1 tab po daily with food		
☐ Stribild	☐ 150/150/200/300	1 tab po Daily (CrCl>70ml/min)		
☐ Trizivir	☐ 300/150/300	1 tab po BID (CrCl > 50ml/min)		
☐ Triumeq	☐ 600/50/300	1 tab po Daily		
☐ Truvada	☐ 200/300	☐ 1 tab po Daily (CrCl > 50ml/min) ☐ 1 tab po Q48h (CrCl 30-49ml/min)		
☐ Evotaz	☐ 300/150	_____mg _____Time(s)/day		
☐ Prezcobix	☐ 800/150	_____mg _____Time(s)/day		
☐ Genvoya	☐ 150/150//200/10	1 tab po Daily (CrCl > 30ml/min)		
Fusion Inhibitor				
☐ Fuzeon	☐ 90	90mg SQ BID (CrCl > 35ml/min)		

DRUG	STRENGTH	DIRECTIONS	QTY	REFILL
NNRTIs				
☐ Intelence	☐ 100 ☐ 200	_____mg _____Time(s)/day		
☐ Rescriptor	☐ 400	_____mg _____Time(s)/day		
☐ Sustiva	☐ 200 ☐ 600	_____mg _____Time(s)/day		
☐ Viramune	☐ 200 ☐ 400XR ☐ 50mg/5mL	_____mg _____Time(s)/day		
☐ Edurant	☐ 25	_____mg _____Time(s)/day		
Protease Inhibitors				
☐ Prezista	☐ 150 ☐ 600 ☐ 800 ☐ 100mg/mL	_____mg _____Time(s)/day		
☐ Crixivan	☐ 200 ☐ 400	_____mg _____Time(s)/day		
☐ Invirase	☐ 200 ☐ 500	_____mg _____Time(s)/day		
☐ Lexiva	☐ 700	_____mg _____Time(s)/day		
☐ Norvir	☐ 100 ☐ 80mg/mL	_____mg _____Time(s)/day		
☐ Aptivus	☐ 250 ☐ 100mg/mL	_____mg _____Time(s)/day		
☐ Reyataz	☐ 200 ☐ 300	_____mg _____Time(s)/day		
☐ Viracept	☐ 250 ☐ 625	_____mg _____Time(s)/day		
Integrase Inhibitors/ CCR5 Inhibitors				
☐ Isentress	☐ 25 ☐ 100 ☐ 400	_____mg _____Time(s)/day		
☐ Selzentry	☐ 150 ☐ 300	_____mg _____Time(s)/day		
☐ Tivicay	☐ 50	_____mg _____Time(s)/day		
☐ Vitekta	☐ 85 ☐ 150	_____mg _____Time(s)/day		
Other				
☐Tybost	☐150	☐1 tab po daily with food		
☐_____	☐_____	☐_____		
☐_____	☐_____	☐_____		
☐_____	☐_____	☐_____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payors, processors and other entities.*

Prescriber's Signature: _____Date_____