CEDRA

HIV
REFERRAL FORM

FAX: 888.889.7129
TOLL FREE: 844.233.7279
CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:

SSN#: Language: ☐ English ☐ Other

Address: Sex: ☐ Male ☐ Female Height: Weight: ☐ lbs ☐ kg

City: State: Zip: Known Allergies:

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:

Address: Phone: E-mail:

City: State: Zip: Key Contact: Phone: Fax:

STATUS UPDATE PREFERENCE: ☐ Phone ☐ Text ☐ Fax ☐ E-mail:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis: ICD-10 Code: Serum Creatinine:

Prior Treatment Regimen, Date, Reason For DC:

CD4 Count: Viral Load: Date of Labs: Any pertinent genotype or phenotype testing available: ☐ Yes (please fax profile) ☐ No

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
SINGLE TABLET				
☐ ATRIPLA®	___ mg Tablet	Take 1 tablet daily without food.		
☐ COMPLERA®	___ mg Tablet	Take 1 tablet daily with food.		
☐ GENVOYA®	___ mg Tablet	Take 1 tablet daily with food.		
☐ ODEFSEY®	☐ 200/25/25 Tablet	One tablet taken orally once daily with a meal NOTE: Hep B testing required		
☐ STRIBILD®	___ mg Tablet	Take 1 tablet daily with food.		
☐ TRIUMEQ®	___ mg Tablet	Take 1 tablet daily.		
Protease Inhibitors				
☐ APTIVUS	☐ 250 mg Capsule	Two 250 capsules co-administered with 200 mg of ritonavir, twice daily.		
☐ CRIXIVAN®	☐ 200 mg Capsule ☐ 400 mg Capsule	800 mg orally every 8 hours NOTE: CRIXIVAN must be taken at intervals of 8 hours. For optimal absorption, CRIXIVAN should be administered without food but with water 1 hour before or 2 hours after a meal.		
☐ EVOTAZ™	___ mg Tablet	Take 1 tablet daily with food.		
☐ INVIRASE®	☐ 200 mg Capsule ☐ 500 mg Tablet	☐ 1000 mg twice daily in combination with ritonavir 100 mg twice daily. ☐ Treatment-naive patients initiating treatment with INVIRASE/ritonavir: First 7 days of treatment: INVIRASE 500 mg twice daily with ritonavir 100 mg twice daily and then 1000 mg twice daily with ritonavir 100 mg twice daily. NOTE: INVIRASE must be administered in combination with ritonavir		
☐ KALETRA®	___ mg Tablet	Take 1 tablet ___ times daily.		
☐ LEXIVA®	☐ 700 mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ NORVIR®	☐ 100 mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ PREZCOBIX®	___ mg Tablet	Take 1 tablet daily with food.		
☐ PREZISTA®	___ mg Tablet	Take ___ tablet(s) ___ times daily with food.		
☐ REYATAZ®	___ mg Capsule	Take ___ capsule(s) daily with food.		
☐ VIRACEPT®	___ mg Tablet	Take ___ tablet(s) ___ times daily with food.		
Entry Inhibitors				
☐ FUZEON®	☐ 90 mg injection	Inject 90mg under skin 2 times daily.		
☐ SELZENTRY®	___ mg tablets	Take ___ tablet(s) ___ times daily.		
Pharmacokinetic Enhancers				
☐ TYBOST®	☐ 150 mg Tablet	Take ___ tablet(s) ___ times daily with food.	___ w/ ☐ Atazanavir ☐ Darunavir	

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
NNRTIs				
☐ EDURANT®	☐ 25 mg Tablet	Take 1 tablet daily with food.		
☐ INTELENCE®	___ mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ RESCRIPTOR®	☐ 200 mg Tablet	Take 2 tablets 3 times daily.		
☐ SUSTIVA®	☐ 600 mg Tablet	Take 1 tablet at bedtime.		
☐ VIRAMUNE®	___ mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ VIRAMUNE® XR	___ mg Tablet			
NRTIs				
☐ COMBIVIR®	___ mg Tablet	Take 1 tablet 2 times daily.		
☐ DESCOVY	☐ 200 mg/25 Tablet	One tablet taken once daily with or without food in patients 12 years old and older with body weight at least 35 kg and a creatinine clearance greater than or equal to 30 mL per minute. Note: HEP B testing required.		
☐ EMTRIVA®	☐ 200 mg Capsules	Take 1 capsule daily.		
☐ EPIVIR®	___ mg Tablet	Take 1 tablet ___ times daily.		
☐ EPZICOM®	___ mg Tablet	Take 1 tablet daily.		
☐ RETROVIR®	☐ 300 mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ TRIZIVIR®	___ mg Tablet	Take 1 tablet 2 times daily.		
☐ TRUVADA®	___ mg Tablet	Take 1 tablet daily.		
☐ VIDEX EC®	___ mg Capsules	Take 1 capsule daily without food.		
☐ VIREAD®	☐ 300 mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ ZERIT®	___ mg Capsules	Take 1 capsule every 12 hours.		
☐ ZIAGEN®	☐ 300 mg Tablet	Take ___ tablet(s) ___ times daily.		
Integrase Inhibitors				
☐ ISENTRESS®	☐ 400 mg Tablet	Take 1 tablet 2 times daily.		
☐ TIVICAY®	☐ 50 mg Tablet	Take ___ tablet(s) ___ times daily.		
☐ VITEKTA®	___ mg Tablet	Take 1 tablet daily with food.		
Other Medications				
☐ BACTRIM	☐ 400/80 ☐ 800/160			
☐ AZITHROMYCIN	___ mg Tablet			

Deliver To: ☐ Patient Home ☐ MD Office

Prescriber Signature: (Please sign and date below.)

Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

SUBMIT FORM CLEAR FORM