HIV REFERRAL FORM

Date: _____

SUPERIOR BIOLOGICS
Fax Referral To: 914-747-1170
Phone: 855-747-1150

SUPERIOR BIOLOGICS

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:** _____