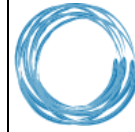


HIV REFERRAL FORM

Y Medical Associates

Fax: 855-838-0623

Phone: 800-447-7558



YMedical
ASSOCIATES

Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell 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: _____ Height: _____ Allergies: _____

MEDICATION	DOSE/STRENGTH	QUANTITY	REFILLS	MEDICATION	DOSE/STRENGTH	QUANTITY	REFILLS
------------	---------------	----------	---------	------------	---------------	----------	---------

NRTI'S

<input type="checkbox"/> Abacavir®	_____	_____	_____
<input type="checkbox"/> Emtriva®	_____	_____	_____
<input type="checkbox"/> Efavirenz®	_____	_____	_____
<input type="checkbox"/> Retrovir®	_____	_____	_____
<input type="checkbox"/> Videx®	_____	_____	_____
<input type="checkbox"/> Viread®	_____	_____	_____
<input type="checkbox"/> Zerit®	_____	_____	_____
<input type="checkbox"/> Ziagen®	_____	_____	_____

NNRTI'S

<input type="checkbox"/> Edurant®	_____	_____	_____
<input type="checkbox"/> Intelence®	_____	_____	_____
<input type="checkbox"/> Rescriptor®	_____	_____	_____
<input type="checkbox"/> Sustiva®	_____	_____	_____
<input type="checkbox"/> Viramune®	_____	_____	_____

Combo / ARV's

<input type="checkbox"/> Atripla®	_____	_____	_____
<input type="checkbox"/> Combivir®	_____	_____	_____
<input type="checkbox"/> Descovy®	_____	_____	_____
<input type="checkbox"/> Epzicom®	_____	_____	_____
<input type="checkbox"/> Genvoya®	_____	_____	_____
<input type="checkbox"/> Juluca®	_____	_____	_____
<input type="checkbox"/> Odesfey®	_____	_____	_____
<input type="checkbox"/> Triumeq®	_____	_____	_____
<input type="checkbox"/> Trizivir®	_____	_____	_____

Integrase Inhibitors

<input type="checkbox"/> Isentress®	_____	_____	_____
<input type="checkbox"/> Tivicay®	_____	_____	_____
<input type="checkbox"/> Truvada®	_____	_____	_____
<input type="checkbox"/> Vitekta®	_____	_____	_____

Protease Inhibitors

<input type="checkbox"/> Aptivus®	_____	_____	_____
<input type="checkbox"/> Crixivan®	_____	_____	_____
<input type="checkbox"/> Evotaz®	_____	_____	_____
<input type="checkbox"/> Invirase®	_____	_____	_____
<input type="checkbox"/> Kaletra®	_____	_____	_____
<input type="checkbox"/> Lexiva®	_____	_____	_____
<input type="checkbox"/> PrezcoBix®	_____	_____	_____
<input type="checkbox"/> Prezista®	_____	_____	_____
<input type="checkbox"/> Reyataz®	_____	_____	_____
<input type="checkbox"/> Viracept®	_____	_____	_____

Entry Inhibitors

<input type="checkbox"/> Fuzeon®	_____	_____	_____
<input type="checkbox"/> Selzentry®	_____	_____	_____

Boosting Agents

<input type="checkbox"/> Norvir®	_____	_____	_____
<input type="checkbox"/> Tybost®	_____	_____	_____

Other/Notes: _____

Prescriber Signature: _____ DAW (Dispense as Written) Date: _____