COTTRILL'S SP
1-844-268-8745

HIV THERAPY
PATIENT REFERRAL & Rx FORM

PLEASE INCLUDE ALL MEDICAL RECORDS AND LABS
PLEASE FAX TO 1-716-508-8482

PATIENT INFORMATION

Last Name _____ First Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Gender: ☐ Male ☐ Female Height _____ Weight _____ Social Security # _____

Home Phone _____ Cell _____ Email Address _____

Allergies _____ Emergency Contact Name _____ Phone _____

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

Secondary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

CLINICAL INFORMATION

Primary Diagnosis: _____ Diagnosis Code: _____ CD4 Count: _____ Date: _____

Secondary Diagnosis: _____ Diagnosis Code: _____ Viral Load: _____ Date: _____

MEDICATIONS

☐ **Atripla**® 600 /300 /200 mg tablets
(Efavirenz/Tenofovir/Emtricitabine)
Qty: 30 tablets
Take 1 tablet by mouth once daily on an empty stomach
Refills:

☐ **Fuzeon**® 90 mg injection
(Enfuvirtide)
Qty: 1 kit
Inject ____ mg ____ times daily
Refills:

☐ **Norvir**® 100 mg tablets
(Ritonavir)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Stribild**® 150/150/200/300 mg tablets
(Cobicistat/Elvitegravir/Emtricitabine/Tenofovir)
Qty: 30 tablets
Take 1 tablet by mouth once daily
Refills:

☐ **Viramune XR**® ____ mg tablets
(Nevirapine ER)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Combivir**® 150 /300 mg tablets
(Lamivudine/Zidovudine)
Qty: 60 tablets
Take 1 tablet by mouth twice daily
Refills:

☐ **Genvoya**® 150/150/200/10 mg tablets
(Elvitefravir/Cobicistat/Emtricitabine/Tenofovir)
Qty: 30 tablets
Take 1 tablet by mouth once daily with food
Refills:

☐ **Prezcobix™** 800/150 mg tablets
(Darunavir/Cobicistat)
Qty: 30 tablets
Take 1 tablet by mouth once daily with food
Refills:

☐ **Sustiva**® 600 mg tablets
(Efavirenz)
Qty: 30 tablets
Take 1 tablet by mouth at bedtime
Refills:

☐ **Viread**® ____ mg tablets
(Tenofovir)
Qty: tablets
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Complera**® 200/25/300 mg tablets
(Emtricitabine/Rilpivirine/Tenofovir)
Qty: 30 tablets
Take 1 tablet by mouth once daily with food
Refills:

☐ **Intelence**® ____ mg tablets
(Etravirine)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Prezista**® ____ mg tablets
(Darunavir)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Tivicay**® 50 mg tablets
(Dolutegravir)
Qty: 1 month supply
Take 1 tablet by mouth ____ times daily
Refills:

☐ **Vitekta**® ____ mg tablets
(Elvitegravir)
Qty: ____ tablets
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Edurant**® 25 mg tablets
(Rilpivirine)
Qty: 30 tablets
Take 1 tablet by mouth once daily with food
Refills:

☐ **Invirase**® ____ mg capsules
(Saquinavir)
Qty: ____ capsules
Take ____ capsules(s) by mouth times daily
Refills:

☐ **Rescriptor**® 200 mg tablets
(Delavirdine)
Qty: 180 tablets
Take 2 tablets by mouth three times daily
Refills:

☐ **Triumeq**® 600/50/300 mg tablets
(Abacavir /Dolutegravir/Lamivudine)
Qty: 30 tablets
Take 1 tablet by mouth daily on an empty stomach
Refills:

☐ **Ziagen**® 300 mg tablets
(Abacavir)
Qty: 60 tablets
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Emtriva**® 200 mg capsules
(Emtricitabine)
Qty: 30 capsules
Take 1 capsule by mouth once daily
Refills:

☐ **Isentress**® 400 mg tablets
(Raltegravir)
Qty: 60 tablets
Take 1 tablet by mouth twice daily
Refills:

☐ **Retrovir**® ____ mg tablets
(Zidovudine)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Trizivir**® 300/150/300 mg tablets
(Abacavir/Lamivudine/Zidovudine)
Qty: 60 tablets
Take 1 tablet by mouth twice daily
Refills:

Other:

☐ **Epivir**® ____ mg tablets
(Lamivudine)
Qty: 1 month supply
Take 1 tablet by mouth ____ times daily
Refills:

☐ **Kaletra**® 200/50 mg tablets
(Lopinavir/Ritonavir)
Qty: 120 tablets
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Reyataz**® ____ mg capsules
(Atazanavir)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Truvada**® 200/300 mg tablets
(Emtricitabine/Tenofovir)
Qty: 30 tablets
Take 1 tablet by mouth once daily
Refills:

Other:

☐ **Epzicom**® 600/300 mg tablets
(Abacavir/Lamivudine)
Qty: 30 tablets
Take 1 tablet by mouth once daily
Refills:

☐ **Lexiva**® 700 mg tablets
(Fosamprenavir Calcium)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Selzentry**® ____ mg tablets
(Maraviroc)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

☐ **Viramune**® ____ mg tablets
(Nevirapine)
Qty: 1 month supply
Take ____ tablet(s) by mouth ____ times daily
Refills:

Other:

PHYSICIAN INFORMATION

Physician Name _____ NPI# _____ DEA# _____

License # _____ State _____ Office Contact _____ Phone _____

Address _____ City _____ State _____ Zip _____ Fax _____

Product Selection Permitted **Dispense as Written** **Date**

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments