Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

COMMUNITY SPECIALTY PHARMACY

Your Choice For Better Health

HIV / AIDS Prescription Referral Form

For additional forms, please contact your Account Manager or visit www.comsprx.com | If you need a medication not listed, please contact us.

Date Medication Needed: ________ Ship To: ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): ________ Injection training by pharmacy? ☐

1: Patient Information

Patient Name: ________ Birthdate: ________ Sex: ○ Male ○ Female Height: ________ Weight: ________ ○ lbs. ○ kg.

Soc. Sec. #: ________ Preferred Phone: ________ Known Allergies: ________

Address: ________ City: ________ State: ________ Zip: ________

Alternate Caregiver Name: ________ Preferred Phone: ________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: ________ DEA#: ________ NPI#: ________ Tax ID#: ________

Address: ________ Phone: ________ Fax: ________

City, State, Zip: ________ Key Contact: ________ Phone: ________

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: ________ ICD-10: ________ Serum Creatinine: ________

CD4 Count: ________ Viral Load: ________ Date of labs: ________

4: Prescription Information

Aptivus® 250mg caps Dispense 1 month supply Take 2 caps 2X daily Refill X ☐	**Atripla®** 600/300/200mg tabs Dispense 30 tabs Take 1 tab QD on empty stomach Refill X ☐	**Combivir®** 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐	**Complera** 200mg/25mg/300mg Dispense 1 month supply Take 1 tab once daily w/ meal Refill X ☐	**Emtriva®** 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X ☐
Edurant® 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X ☐	**Epivir®** ☐ mg caps Dispense 1 month supply Take 1 cap ☐ X daily Refill X ☐	**Epzicom®** 600mg/300mg tabs Dispense 1 month supply Take 1 tab daily Refill X ☐	**Evotaz** 300/150 Dispense 30 tablets Take 1 tab QD with a light meal Refill X ☐	**Fuzeon®** 90mg Inj Dispense 1 kit Inject 90mg under skin 2x daily Refill X ☐
Genvoya® 150/150/200/10 tabs Dispense 30 tabs Take 1 tab daily with food Refill X ☐	**Intelence®** 200 mg tabs Dispense 1 month supply Take 1 tab 2X daily Refill X ☐	**Isentress®** 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐	**Kaletra®** 200/50mg tabs Dispense 120 tabs Take ☐ tabs ☐ X daily Refill X ☐	**Lexiva®** 700mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐
Mepron® 750mg/5ml ☐ sachet ☐ suspension Dispense ☐ day supply Take ☐ ml ☐ X daily Refill X ☐	**Norvir®** 100mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Odefsey™** 200mg/25mg/25mg Dispense 30 tabs Take 1 tab daily with food Refill X ☐	**Prezcobix** 800/150 Dispense 30 tablets Take 1 tab daily with food Refill X ☐	**Prezista®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐
Rescriptor® 200mg caps Dispense 180 capsules Take 2 caps 3X daily Refill X ☐	**Retrovir®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Reyataz®** ☐ mg caps Dispense 1 month supply Take ☐ caps ☐ X daily Refill X ☐	**Selzentry®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Serostim®** ☐ mg Dispense 1 month supply Inject ☐ mg SC daily Refill X ☐
Stribild™ tablets Dispense 1 month supply Take 1 tablet daily Refill X ☐	**Sustiva®** 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X ☐	**Tivicay** 50mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Triumeq** 50/600/300 Dispense 30 tablets Take 1 tablet by mouth daily with or without food Refill X ☐	**Trizivir®** 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐
Truvada® 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X ☐	**Tybost** 150mg tabs Dispense 30 tabs Take 1 tab daily Refill X ☐	**Viramune®** ☐ mg tabs Dispense ☐ Take ☐ tab ☐ X daily Refill X ☐	**Viread®** 300mg tabs Dispense ☐ tablets Take ☐ daily Refill X ☐	**Vitekta** ☐ mg tabs Dispense 1 month supply Take 1 tab daily Refill X ☐
Ziagen® 300mg tabs Dispense 60 tabs Take ☐ tab ☐ X daily Refill X ☐	**Zerit®** ☐ mg caps Dispense 1 month supply Take ☐ mg 2X daily Refill X ☐	**Zithromax®** 600mg tabs Take ☐ tabs ☐ X daily Take ☐ tabs ☐ X weekly Refill X ☐	**Other:** ☐ ☐ ☐ Refill X ☐	**Other:** ☐ ☐ ☐ Refill X ☐

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ________ Date: ________

Prescriber Signature: Prescriber, please sign and date below

Dispense as written ________ Date ________ Substitution Permissable ________ Date ________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: ________