

HIV / AIDS Prescription Referral Form

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 _____	Tyboost 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 Permissible

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/NT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____