



### HIV/AIDS PRESCRIPTION

Phone:(951)530-8800

Fax: (951)530-4801

#### PATIENT

PatientName: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone:( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

#### PHYSICIAN

MDName: \_\_\_\_\_ License: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone:( ) \_\_\_\_\_ Fax:( ) \_\_\_\_\_ Contact: \_\_\_\_\_

#### CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-10 Codes: \_\_\_\_\_ SerumCreatinine: \_\_\_\_\_  
CD4 Count: \_\_\_\_\_ ViralLoad: \_\_\_\_\_ Date of Labs: \_\_\_\_\_

#### PRESCRIPTION INFORMATION

<p><b>ATRIPLA</b> tabs Dispense 30 tabs Take 1 tab daily on stomach Refill: _____</p> <p><b>EDURANT 25mg tabs</b> Dispense 30 tabs Take 1 tab daily with Refill: _____</p> <p><b>ISENTRESS 400mg tabs</b> Dispense 60 tabs Take 1 tab 2x daily Refill: _____</p> <p><b>PREZISTA _____ mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p><b>SEROSTIM _____ mg</b> Inject _____ mgSC daily Refill: _____</p> <p><b>VIRAMUNE _____ mg tabs</b> Dispense _____ Take _____ tab _____ _____ xdaily Refill:</p>	<p><b>COMBIVIR</b> tabs Dispense 60 tabs Take 1 tab 2x daily Refill: _____</p> <p><b>EPIVIR _____ mg tabs</b> Dispense 1 month supply Take 1 tab _____ xdaily Refill: _____</p> <p><b>KALETRA 200/50mg tabs</b> Dispense 120 tabs Take _____ tabs _____ daily Refill: _____</p> <p><b>RESCRIPTOR 200mg tabs</b> Dispense 180 tabs Take 2 tabs 3x daily</p> <p><b>STRIBILD tablets</b> Take 1 tablet daily Refill: _____</p> <p><b>VIREAD 300mg tabs</b> Dispense _____ _____ tablets Take _____ daily Refill: _____</p>	<p><b>COMPLERA</b> 200mg/25mg/300mg Dispense 1 month supply Take 1 tab once daily w/meal Refill: _____</p> <p><b>EPZICOM 600mg/300mg tab</b> Dispense 1 month supply Take one tablet daily Refill: _____</p> <p><b>LEXIVA 700mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p><b>RETROVIR _____ mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p><b>SUSTIVA 600mg tablets</b> Dispense 30 tablets Take 1 tab at bedtime Refill: _____</p> <p><b>ZIAGEN 300mg tabs</b> Dispense 60 tabs Take _____ tabs _____ xdaily Refill: _____</p>	<p><b>EGRIFTA</b> requires referral form. Please call Pharmacy for more information.</p> <p><b>FUZEON 90mg injection</b> Dispense 1 kit Inject 90mg SO 2x daily Refill: _____</p> <p><b>MEPRON 750mg/5ml _____ sachet</b> _____ suspension Dispense _____ days supply Take _____ ml _____ xdaily Refill: _____</p> <p><b>REYATAZ _____ mg caps</b> Dispense 1 month supply Take _____ caps _____ xdaily Refill: _____</p> <p><b>TRIZIVIR 300/150/300mg tabs</b> Dispense 60 tabs Refill: _____</p> <p><b>ZITHROMAX 600mg tabs</b> Take _____ tabs _____ xdaily Take _____ tabs Refill: _____</p>	<p><b>EMTRIVA 200mg caps</b> Dispense 30 capsules Take 1 cap once daily Refill: _____</p> <p><b>INTELENCE _____ mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p><b>NORVIR 100mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p><b>SELZENTRY _____ mg tabs</b> Dispense 1 month supply Take _____ tabs _____ xdaily Refill: _____</p> <p>_____ tabs Dispense 30 tabs Take 1 tab once daily Refill: _____</p> <p><b>OTHER:</b> _____ _____ _____ Refill: _____</p>
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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

By signing above, the prescriber gives consent to both, the prescription(s) above, as well as to RX Biotech Specialty Pharmacy/Beverly Sinai Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.  
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