HIV PRESCRIPTION REFERRAL FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Sex □ M □ F

Date of Birth _____

Home Phone _____ Work/Mobile _____

Home Address _____ City/Zip _____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____

Subscriber Name _____

Policy No _____ Group No _____

Prescription Card Bin # _____ PCN # _____

PRESCRIPTION INFORMATION

NRTIs

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILL
□ Emtriva	200mg			
□ Epivir				
□ Retrovir				
□ Videx				
□ Viread	300mg			
□ Ziagen				

Combination Antiretrovirals

□ Symtuza	800/150/200/10			
□ Delstrigo	100/300/300			
□ Biktarvy	50/200/25			
□ Juluca	50/25			
□ Atripla	300/200/600			
□ Combivir	300/150			
□ Complera	300/200/25			
□ Epzicom	600/300			
□ Stribild	150/200			
□ Trizivir	300/150/300			
□ Triumeq	50/600/300			
□ Truvada	300/200			
□ Genvoya	150/150/200/10			
□ Descovy	200/25			
□ Prezcobix				
□ Odefsey				
□ Abacavir-Lamivudine-Zidovudine				
□ Lamivudine				
□ Zidovudine				
□ Lamivudine-Zidovudine				

NNRTIs

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILL
□ Edurant	25mg			
□ Intelence	100mg			
□ Sustiva				
□ Viramune				

Integrase Inhibitors

□ Isentress	400mg			
□ Tivicay				

Protease Inhibitors

□ Aptivus	250mg			
□ Crixivan				
□ Invirase				
□ Kaletra	200/50			
□ Lexiva	700mg			
□ Norvir Tab	100mg			
□ Prezista				
□ Reyataz				
□ Viracept				

Entry Inhibitors

□ Fuzeon	90mg vial			
□ Selzentry				
□ Trogarzo				

Other Medications

□ Acyclovir				
□ Bactrim				
□ Diflucan				
□ Procrit				
□ Serostim				
□ Valtrex				
□ Egrifta				

Physician's Signature: _____ **Date:** _____ **Office Manager:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **DEA:** _____ **NPI:** _____

By Signing this enrollment form you authorize Southside Pharmacy to call Insurance companies on behalf of you for prior authorization purposes.

Fax your referral to (470) 377-4055

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