Faxed prescription will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

HIV / AIDS Prescription Referral Form

1403 Highway 6 Suite 700A, Sugar Land, TX 77478 **Phone: 832.944.6112** **Fax: 832.944.6116**

Choice Infusion Center "Infuse to better health"

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)

Prescriber Information

Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

Diagnosis/Clinical Information

Please FAX recent clinical notes, Labs, Tests, with the prescription to expidite the Prior Authorization

Diagnosis: _____ **ICD-9:** _____ **Serum Creatinine:** _____

CD4 Count: _____ **Vital Load:** _____ **Date of Labs:** _____

Prescription Information

__ **Aptivus®** 250mg Caps Dispense 60 caps Take 2 caps two times daily. Refill:___	__ **Atripla®** 600/300/200mg tabs Dispense 30 tabs Take 1 tab daily 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	__ **Crixivan®** Dispense 1 month supply Take __ 400mg caps __X daily. Drink water to avoid kidney stones.
__ **Edurant®** 25mg tabs Dispense 30 tabs Take 1 daily with meal Refill X	__ **Emtriva®** 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X	__ **Epivir®** mg tabs Dispense 1 month supply Take 1 tab __X daily Refill X	__ **Epzicom®** 600mg/300mg tabs Dispense 1 month supply Take 1 tablet daily Refill X	__ **Evotaz®** 300/150 Dispense 30 tabs Take 1 tab with light meal Refill:___
__ **Genvoya®** 150/150/200/10 tabs Dispense 30 tabs Take 1 tab daily. Refill:___	__ **Intelence®** mg tabs Dispense 1 month supply Take __tabs __X daily Refill X	__ **Isentress®** 400mg tabs Dispense 60 tabs Take 1 tab 2x daily Refill X	__ **Kaletra®** 200mg/50mg tabs Dispense 120 tabs Take __tabs __X daily Refill X	__ **Lexiva®** 700mg tabs Dispense 1 month supply Take __tabs __X daily Refill X
__ **Norvir®** 100 mg 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:___	__ **Prezcobix®** Dispense 30 tabs Take 1 tab PO	__ **Rescriptor®** 200mg tabs Dispense 180 tabs Take 2 tabs 3x daily Refill X	__ **Retrovir®** mg tabs Dispense 1 month supply Take __tab __X daily Refill X
__ **Reyataz®** mg tabs Dispense 1 month supply Take __tab __X daily Refill X	__ **Selzentry®** mg tabs Dispense 1 month supply take __tabs __X daily Refill X	__ **Stribild®** tablets 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:___
__ **Triumeq®** 50/600/300 Dispense 30 tablets Take 1 tab daily with or without food Refill:___	__ **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 tab Dispense 30 tabs Take 1 tab daily Refill:___	__ **Viramune®** mg tabs Dispense__tablet Take __tab __X daily Refill X
__ **Viread®** 300mg tabs Dispense __tablet Take __daily Refill X	__ **Vitekta®** ___mg tabs Dispense 30 tabs Take 1 tab daily Refill:___	__ **Ziagen®** 300mg tabs Dispense 60 tabs Take tab X daily Refill X	**Other:** _____ _____ _____	

Date Medication Needed: ____/____/_____ **Ship To:** ____ Patient's Home _____ Pick-up (store location): _____

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 recepient, do not dessiminate, 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 permittted per order form. Please use a new form for additional items.

# of Prescriptions: _____