HIV PRESCRIPTION REFERRAL FORM

DELMARVA SPECIALTY PHARMACY AT WOODBROOKE
1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis Weight Allergies CD4 Viral Load

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg
Tabs | Sol #____ Refill x ____ Sig ____

DESCOVY 200/25mg
Tabs #____ Refill x ____ Sig ____

EMTRIVA 200mg
Caps #____ Refill x ____ Sig ____

EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

EPZICOM 600/300mg
Tabs #____ Refill x ____ Sig ____

RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

TRIZIVIR 300/150/300mg
Tabs | Sol #____ Refill x ____ Sig ____

TRUVADA 200/300mg
Tabs | Sol #____ Refill x ____ Sig ____

VIDEX EC 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd #____ Refill x ____ Sig ____

VIREAD 300mg
Tabs | Sol #____ Refill x ____ Sig ____

ZERIT
15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol #____ Refill x ____ Sig ____

ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs | Sol #____ Refill x ____ Sig ____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps #____ Refill x ____ Sig ____

CRIXIVAN 200mg 333mg 400mg
Caps #____ Refill x ____ Sig ____

EVOTAZ 300mg 150mg
Tabs #____ Refill x ____ Sig ____

INVIRASE 200mg 500mg
Caps | Sol #____ Refill x ____ Sig ____

KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #____ Refill x ____ Sig ____

LEXIVA 700mg Oral Susp. 50mg/ml
Tabs #____ Refill x ____ Sig ____

NORVIR 100mg 80mg/ml
Caps | Sol #____ Refill x ____ Sig ____

PREZCOBIX 800mg 150mg
Tabs #____ Refill x ____ Sig ____

PREZISTA 75mg 150mg 400mg 600mg
Tabs | Sol #____ Refill x ____ Sig ____

REYATAZ 100mg 150mg 200mg 300mg
Caps #____ Refill x ____ Sig ____

VIRACEPT 250mg 625mg
Tabs | Pwd #____ Refill x ____ Sig ____

FUSION INHIBITORS **FUZEON** 90mg Refill x ____ Sig ____

HGH **SEROSTIM** 4mg Refill x ____ Sig ____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs #____ Refill x ____ Sig ____

INTELENCE 100 mg 200mg
Tabs #____ Refill x ____ Sig ____

RESCRIPTOR 200mg
Caps #____ Refill x ____ Sig ____

SUSTIVA 50mg 200mg 600mg
Tabs | Caps #____ Refill x ____ Sig ____

VIRAMUNE 200mg 50mg/5ml
Tabs | Sol #____ Refill x ____ Sig ____

OTHER MEDICATIONS

ATRIPLA Tabs #____ Refill x____ Sig ____
COMPLERA Tabs #____ Refill x____ Sig ____
GENVOYA 150/150/200/10mg Tabs #____ Refill x____ Sig ____
ISENTRESS 400 mg Tabs #____ Refill x____ Sig ____
ODEFSEY Tabs #____ Refill x____ Sig ____
STRIBILD Tabs #____ Refill x____ Sig ____

OTHER ____ Tabs #____ Refill x ____ Sig ____

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ____ **Date** ____

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