



MORRISTOWN PHARMACY

HIV PRESCRIPTION REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel: 973 - 998 - 0287 | Fax: 973 - 998 - 0288

Today's Date

Anticipated Start Date

NEW PATIENT CURRENT PATIENT

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

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 _____ 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 _____	TRIZIVIR 300/150/300mg Tabs Sol # _____ Refill x _____ Sig _____
DESCOVI 200/25mg Tabs # _____ Refill x _____ Sig _____	TRUVADA 200/300mg Tabs Sol # _____ Refill x _____ Sig _____
EMTRIVA 200mg Caps # _____ Refill x _____ Sig _____	VIDEX EC 125mg 200mg 250mg 400mg PLAIN VIDEX SOLUTION 10mg/ml Tabs Pwd # _____ Refill x _____ Sig _____
EPIVIR 150mg 300mg 10mg/ml Tabs Sol # _____ Refill x _____ Sig _____	VIREAD 300mg Tabs Sol # _____ Refill x _____ Sig _____
EPZICOM 600/300mg Tabs # _____ Refill x _____ Sig _____	ZERIT 15mg 20mg 30mg 40mg Oral Sol. 1mg/ml Caps Sol # _____ Refill x _____ Sig _____
RETROVIR 100mg 300mg Oral Sol. 10mg/ml Tabs 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 _____	LEXIVA 700mg Oral Susp. 50mg/ml Tabs # _____ Refill x _____ Sig _____
CRIXIVAN 200mg 333mg 400mg Caps # _____ Refill x _____ Sig _____	NORVIR 100mg 80mg/ml Caps Sol # _____ Refill x _____ Sig _____
EVOTAZ 300mg 150mg Tabs # _____ Refill x _____ Sig _____	PREZCOBIX 800mg 150mg Tabs # _____ Refill x _____ Sig _____
INVIRASE 200mg 500mg Caps Sol # _____ Refill x _____ Sig _____	PREZISTA 75mg 150mg 400mg 600mg Tabs Sol # _____ Refill x _____ Sig _____
KALETRA 100mg/25mg 200mg/50mg 400mg/100mg/5ml 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 _____

OTHER MEDICATIONS

ATRIPLA	Tabs # _____ Refill x _____ Sig _____
COMPLERA	Tabs # _____ Refill x _____ Sig _____
ISENTRESS 400 mg	Tabs # _____ Refill x _____ Sig _____
ODEFSEY	Tabs # _____ Refill x _____ Sig _____
STRIBILD	Tabs # _____ Refill x _____ Sig _____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg Tabs # _____ Refill x _____ Sig _____	RESCRIPTOR 200mg Caps # _____ Refill x _____ Sig _____
INTELENCE 100 mg 200mg Tabs # _____ Refill x _____ Sig _____	SUSTIVA 50mg 200mg 600mg Tabs Caps # _____ Refill x _____ Sig _____
	VIRAMUNE 200mg 50mg/5ml Tabs Sol # _____ Refill x _____ Sig _____

HGH SEROSTIM 4mg 5mg 6mg Refill x _____ Sig _____

ADDITIONAL MEDICATION _____ Tabs # _____ Refill x _____ Sig _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

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

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