

PATIENT INFORMATION

Last Name _____ First Name _____ Home Address _____
 _____ City _____ State _____ Zip _____ Home Phone _____
 _____ Work/Mobile Phone _____ E-mail _____
 Social Security # _____ Date of Birth _____ Gender: Male Female
 Primary Caregiver _____ Relation _____ Phone _____
 Emergency Contact _____ Relation _____ Phone _____

INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

1. Primary Insurance _____ ID # _____ Group # _____ Phone _____
 Insured's Name _____ Insured's Employer _____ Relationship _____
 2. Secondary Insurance _____ ID # _____ Group # _____ Phone _____
 Insured's Name _____ Insured's Employer _____ Relationship _____

CLINICAL INFORMATION

ICD-10 Code _____ Primary Diagnosis _____
 Current Weight _____ kg/lbs Height _____ inches/cm BMI _____
 Allergies: Yes No If yes, please list _____

Naive to Treatment Therapy Experienced to Treatment Therapy *please include most current lab results*

MEDICATION NAME	STRENGTH	DOSAGE	QTY	REFILL
NRTIs				
EMTRIVA®	200mg	one tablet taken orally once daily		
EPIVIR®	150mg	[] 150 mg twice daily / [] 300mg once daily		
VIREAD®	300mg	one tablet taken orally once daily		
ZIAGEN®	300mg	[] 300mg twice daily / [] 600mg once daily		
NNRTIs				
EDURANT®	25mg	one tablet taken with a meal		
INTELENCE®	[] 25mg / [] 100mg / [] 200mg	200 mg taken twice daily following a meal		
SUSTIVA®	[] 50mg caps / [] 200mg caps / [] 600mg tabs			
VIRAMUNE XR™	400mg			
Protease Inhibitors				
INVIRASE®	[] 200mg cap / [] 500mg tab	1000 mg twice daily within 2 hours after a meal		
LEXIVA®	700mg	Tablet taken orally twice daily		
NORVIR®	100mg [] caps (must refrigerate) [] tabs	600mg twice daily with meals		
PREZISTA®	[] 75mg / [] 150mg / [] 600mg / [] 800mg	_____ Mg taken orally once daily with food		
REYATAZ®	[] 150mg / [] 200mg / [] 300mg	_____ Mg taken orally once daily with food		
Integrase Inhibitors				
ISENTRESS®	400mg	one tablet taken orally twice daily		
TIVICAY®	50mg	[] once daily / [] twice daily		
Combination				
ATRIPLA®	600mg(EFV) / 200mg(FTC) / 300mg(TDF)	one tablet on an empty stomach at bedtime		
COMPLERA®	200mg (FTC) / 25mg (RPV) / 300mg (TDF)	one tablet taken orally once daily with food		
DESCOVY®	200MG (FTC) / 25mg (TAF)	one tablet taken orally once daily		
EPZICOM®	600mg (ABC) / 300mg(3TC)	one tablet taken orally once daily		
GENVOYA®	150mg(EVG) / (COBI) / 200mg (FTC) / 10 (TAF)	one tablet taken orally once daily with food		
KALETRA®	200mg(LPV) / 50mg(R)	[] two tabs twice daily / [] three tabs twice daily		
STRIBILD®	150mg(EVG) / (COBI) / 200mg(FTC) / 300mg(TDF)	one tablet taken orally once daily with food		
TRUVADA®	200mg (FTC) / 300mg(TDF)	one tablet taken orally once daily		
ODEFSEY®	200/25/25mg	one tablet once daily with a meal		

PHYSICIAN INFORMATION

Physician Name _____ Contact Name _____
 NPI # _____ DEA # _____ Lic # _____
 Phone/Fax _____ E-mail _____
 Address _____ City _____ State _____ Zip _____

I authorize to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature _____

Date _____

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