Faxed or E-scribed Prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

Access Specialty Pharmacy

Human Immunodeficiency Syndrome (HIV)/ AIDS Prescription Referral Form (2)

Send your RX to: | Access Specialty Pharmacy Fax: 661-489-3553 | If you have any questions or concerns, Please contact us at 661-489-3500 or toll free (833-647-0821)

Date Medication Needed: _____ **Deliver to**: ☐ Patient's home ☐ Prescriber's office ☐ Pick-up Injection training by pharmacy? _____

1: 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)

2. Prescriber Information

Provider Name: _____ **DEA #:** _____ **NPI#:**_____
Address: _____ **Phone:** _____ **Fax:** _____
City, State, ZIP: _____ **Key Contact:** _____
Phone:_____

3: Diagnostic/Clinical Information

Please FAX recent clinical notes, labs, Tests, with the prescription

Diagnosis: _____ **ICD-10:** _____ **Serum Creatinine:** _____
CD4 Count: _____ **Viral Load:** _____ **Date of Labs:** _____
PrEP: ☐ Yes ☐ No **Hep B test completed?** ☐ Yes ☐ No **Hep C test completed?** ☐ Yes ☐ No
HLA-B*5701 test completed? ☐ Yes ☐ No
☐ **Treatment Experienced Patient** ☐ **Treatment Naïve Patient**

4. Prescription Information

Medication	Dose/Strength	Directions	Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills
☐ Aptivus	☐ 250 mg caps				☐ Kaletra	☐ 400/100/5ml oral soln ☐ 100/25 mg tabs ☐ 200/50 mg tabs			
☐ Atripla	☐ 600mg/200mg tabs				☐ Lexiva	☐ 700 mg tabs			
☐ Combivir	☐ 150/300 mg tabs				☐ Pifeltro	☐ 100 mg tabs			
☐ Complera	☐ 200/25/300 mg tabs				☐ Retrovir	☐ 100 mg caps ☐ 50mg/5ml oral soln ☐ 200mg/20 ml oral soln			
☐ Crixivan	☐ 400 mg caps				☐ Stribild	☐ 150/200 mg tabs			
☐ Delstrigo	☐ 100/300 mg tabs				☐ Sustiva	☐ 50 mg caps ☐ 200 mg caps ☐ 600 tabs			
☐ Edurant	☐ 25 mg tabs				☐ Symfi ☐ Symfi Lo	☐ 600/300/300 mg tab ☐ 400/300/300 mg tabs			
☐ Emtriva	☐ 200 mg caps ☐ 10mg/ml oral soln				☐ Viramune ☐ Viramune XR	☐ 50mg/5ml oral susp ☐ 200 mg tabs ☐ XR: 400 mg tabs			
☐ Epivir	☐ 100 mg tabs ☐ 150 mg tabs ☐ 300 mg tabs ☐ 10mg/ml oral soln				☐ Viread	☐ 40mg/g oral powder ☐ 150 mg tabs ☐ 200 mg tabs ☐ 250 mg tabs ☐ 300 mg tabs			
☐ Epzicom	☐ 600/300 mg tabs				☐ Ziagen	☐ 300 mg tabs ☐ 20 mg/ml oral soln			
☐ Evotaz	☐ 300/150 mg tabs				☐ Other: _____				
☐ Invirase	☐ 500 mg tabs								

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 Permissible** **Date**

# of Prescriptions: _____

I authorize Access Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process