

patient information

patient: _____ male
last name, first name female DOB: _____ SS#: _____

address: _____
street city state zip

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs kg date: _____

clinical information

Diagnosis ICD-10: B20 HIV B18.0 HBV with delta agent (Chronic) B18.1 HBV without delta agent (Chronic) B18.2 HCV (Chronic)

New to current therapy? yes no CD4: _____ date: _____ HIV RNA: _____ date: _____

prescriptions

medication	QTY	refills	medication	QTY	refills
Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)			Retrovir® (zidovudine)		
Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empty stomach			Reyataz® (atazanavir)		
Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)			Selzentry® (maraviroc)		
Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food			Stribid™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
Crixivan® (indinavir) One tablet by mouth QD with a meal			Sustiva® (efavirenz)		
Edurant™ (rilpivirine) 25 mg One capsule by mouth QD			Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
Emtrivia QD® (emtricitabine) 200 mg			Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
Epivir® (lamivudine)			Videx® EC (didanosine)		
Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD			Viracept® (nelfinavir)		
Fuzeon® (enfuvirtide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			Viramune® (nevirapine) 200 mg		
Fuzeon® (enfuvirtide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			Viramune® XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
Intelence® (entravirine)			Viread® (tenofovir) 300 mg		
Invirase® (saquinavir)			Zerit® (stavudine)		
Isentress® (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)			Ziagen® (avacavir) 300 mg		
Kaletra® (lopinavir/ritonavir) 200/50 mg			other medications		
Lexiva® (fosamprenavir) 200/50 mg			Acylovir		
Norvir® (ritonavir) capsules 100 mg			Bactrim® (TMC/SMZ)		
Norvir® (ritonavir) tablets 100 mg			Bactrim® DS(TMP/SMZ)		
Prezista® (darunavir)			Dapsone		
Rescriptor® (delavirdine)			Diflucan® (fluconazole)		
			Serostim® (somatropin)		
			Valtrex® (valacyclovir)		
			Zithromax® (azithromycin)		

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate
shipping address: _____ street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Total Care RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Total Care RX.

insurance information: please fax copy of insurance card (front + back)

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