

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
 SSN#: \_\_\_\_\_ Language: English Other \_\_\_\_\_  
 Address: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Known Allergies: \_\_\_\_\_

**\* PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING \***

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Key Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

STATUS UPDATE PREFERENCE: Phone Text Fax E-mail: \_\_\_\_\_

**DIAGNOSIS/CLINICAL INFORMATION**

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ Serum Creatinine: \_\_\_\_\_  
 Prior Treatment Regimen, Date, Reason For DC: \_\_\_\_\_  
 CD4 Count: \_\_\_\_\_ Viral Load: \_\_\_\_\_ Date of Labs: \_\_\_\_\_ Any pertinent genotype or phenotype testing available: Yes (please fax profile) No

**PRESCRIPTION INFORMATION**

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS	MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
<b>SINGLE TABLET</b>					<b>NNRTIs</b>				
ATRIPLA®	mg Tablet	Take 1 tablet daily without food.			EDURANT®	25 mg Tablet	Take 1 tablet daily with food.		
COMPLERA®	mg Tablet	Take 1 tablet daily with food.			INTELENCE®	mg Tablet	Take tablet(s) times daily.		
GENVOYA®	mg Tablet	Take 1 tablet daily with food.			RESCRIPTOR®	200 mg Tablet	Take 2 tablets 3 times daily.		
ODEFSEY®	200/25/25 Tablet	One tablet taken orally once daily with a meal NOTE: Hep B testing required			SUSTIVA®	600 mg Tablet	Take 1 tablet at bedtime.		
STRIBILD®	mg Tablet	Take 1 tablet daily with food.			VIRAMUNE®	mg Tablet	Take tablet(s) times daily.		
TRILUMEQ®	mg Tablet	Take 1 tablet daily.			VIRAMUNE®XR	mg Tablet			
<b>Protease Inhibitors</b>					<b>NRTIs</b>				
APTIVUS	250 mg Capsule	Two 250 capsules co-administered with 200 mg of ritonavir, twice daily.			COMBIVIR®	mg Tablet	Take 1 tablet 2 times daily.		
CRXIVAN®	200 mg Capsule 400 mg Capsule	800 mg orally every 8 hours NOTE: CRXIVAN must be taken at intervals of 8 hours. For optimal absorption, CRXIVAN should be administered without food but with water 1 hour before or 2 hours after a meal.			DESCOXY	200 mg/25 Tablet	One tablet taken once daily with or without food in patients 12 years old and older with body weight at least 35 kg and a creatinine clearance greater than or equal to 30 mL per minute. Note: HEP B testing required.		
EVOTAZ™	mg Tablet	Take 1 tablet daily with food.			EMTRIVA®	200 mg Capsules	Take 1 capsule daily.		
INVIKASE®	200 mg Capsule 500 mg Tablet	1000 mg twice daily in combination with ritonavir 100 mg twice daily. Treatment-naïve patients initiating treatment with INVIRASE/ritonavir: First 7 days of treatment: INVIRASE 500 mg twice daily with ritonavir 100 mg twice daily and then 1000 mg twice daily with ritonavir 100 mg twice daily. NOTE: INVIRASE must be administered in combination with ritonavir			EPVIR®	mg Tablet	Take 1 tablet times daily.		
KALETRA®	mg Tablet	Take 1 tablet times daily.			EPZICOM®	mg Tablet	Take 1 tablet daily.		
LEXIVA®	700 mg Tablet	Take tablet(s) times daily.			RETRORVIR®	300 mg Tablet	Take tablet(s) times daily.		
NORVIR®	100 mg Tablet	Take tablet(s) times daily.			TRIZIVIR®	mg Tablet	Take 1 tablet 2 times daily.		
PREZCOBIX®	mg Tablet	Take 1 tablet daily with food.			TRUVADA®	mg Tablet	Take 1 tablet daily.		
PREZISTA®	mg Tablet	Take tablet(s) times daily with food.			VIDEX EC®	mg Capsules	Take 1 capsule daily without food.		
REYATAZ®	mg Capsule	Take capsule(s) daily with food.			VIREAD®	300 mg Tablet	Take tablet(s) times daily.		
VIRACEPT®	mg Tablet	Take tablet(s) times daily with food.			ZERT®	mg Capsules	Take 1 capsule every 12 hours.		
					ZIAGEN®	300 mg Tablet	Take tablet(s) times daily.		
<b>Entry Inhibitors</b>					<b>Integrase Inhibitors</b>				
FUZEON®	90 mg injection	Inject 90mg under skin 2 times daily.			ISENTRESS®	400 mg Tablet	Take 1 tablet 2 times daily.		
SELZENTRY®	mg tablets	Take tablet(s) times daily.			TMCAY®	50 mg Tablet	Take tablet(s) times daily.		
					VITEKTA®	mg Tablet	Take 1 tablet daily with food.		
<b>Pharmacokinetic Enhancers</b>					<b>Other Medications</b>				
TYBOST®	150 mg Tablet	Take tablet(s) times daily with food.		w/ Atazanavir Darunavir	BACTRIM	400/80 800/160			
					AZITHROMYCIN	mg Tablet			

Deliver To: Patient Home MD Office

Prescriber Signature: (Please sign and date below.)  
 Your signature authorizes Kings Care Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_ Dispense as written "DAW" \_\_\_\_\_ Date \_\_\_\_\_

