RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

HIV / AIDS Prescription Referral Form

Send your Rx to:

Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____ Injection training by pharmacy? ☐

1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

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: _____

2. Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Diagnosis: _____ **ICD-10:** _____ **Serum Creatinine:** _____
CD4 Count: _____ **Viral Load:** _____ **Date of labs:** _____

4. Prescription Information

Aptivus® 250mg caps Dispense 1 month supply Take 2 caps 2X daily Refill X ☐	**Atripla®** 600/300/200mg tabs Dispense 30 tabs Take 1 tab QD on empty stomach Refill X ☐	**Combivir®** 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐	**Complera** 200mg/25mg/300mg Dispense 1 month supply Take 1 tab once daily w/ meal Refill X ☐	**Emtriva®** 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X ☐
Edurant® 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X ☐	**Epivir®** ☐ mg caps Dispense 1 month supply Take 1 cap ☐ X daily Refill X ☐	**Epzicom®** 600mg/300mg tabs Dispense 1 month supply Take 1 tab daily Refill X ☐	**Evotaz** 300/150 Dispense 30 tablets Take 1 tab QD with a light meal Refill X ☐	**Fuzeon®** 90mg Inj Dispense 1 kit Inject 90mg under skin 2x daily Refill X ☐
Genvoya® 150/150/200/10 tabs Dispense 30 tabs Take 1 tab daily with food Refill X ☐	**Intelence®** 200 mg tabs Dispense 1 month supply Take 1 tab 2X daily Refill X ☐	**Isentress®** 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐	**Kaletra®** 200/50mg tabs Dispense 120 tabs Take ☐ tabs ☐ X daily Refill X ☐	**Lexiva®** 700mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐
Mepron® 750mg/5ml ☐ sachet ☐ suspension Dispense ☐ day supply Take ☐ ml ☐ X daily Refill X ☐	**Norvir®** 100mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Odefsey™** 200mg/25mg/25mg Dispense 30 tabs Take 1 tab daily with food Refill X ☐	**Prezcobix** 800/150 Dispense 30 tablets Take 1 tab daily with food Refill X ☐	**Prezista®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐
Rescriptor® 200mg caps Dispense 180 capsules Take 2 caps 3X daily Refill X ☐	**Retrovir®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Reyataz®** ☐ mg caps Dispense 1 month supply Take ☐ caps ☐ X daily Refill X ☐	**Selzentry®** ☐ mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Serostim®** ☐ mg Dispense 1 month supply Inject ☐ mg SC daily Refill X ☐
Stribild™ tablets Dispense 1 month supply Take 1 tablet daily Refill X ☐	**Sustiva®** 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X ☐	**Tivicay** 50mg tabs Dispense 1 month supply Take ☐ tabs ☐ X daily Refill X ☐	**Triumeq** 50/600/300 Dispense 30 tablets Take 1 tablet by mouth daily with or without food Refill X ☐	**Trizivir®** 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X ☐
Truvada® 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X ☐	**Tybost** 150mg tabs Dispense 30 tabs Take 1 tab daily Refill X ☐	**Viramune®** ☐ mg tabs Dispense ☐ Take ☐ tabs ☐ X daily Refill X ☐	**Viread®** 300mg tabs Dispense ☐ tablets Take ☐ daily Refill X ☐	**Vitekta** ☐ mg tabs Dispense 1 month supply Take 1 tab daily Refill X ☐
Ziagen® 300mg tabs Dispense 60 tabs Take ☐ tabs ☐ X daily Refill X ☐	**Zerit®** ☐ mg caps Dispense 1 month supply Take ☐ mg 2X daily Refill X ☐	**Zithromax®** 600mg tabs Take ☐ tabs ☐ X daily Take ☐ tabs ☐ X weekly Refill X ☐	**Other:** ☐ Refill X ☐	**Other:** ☐ Refill X ☐

5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature _____ **Date** _____

6. Prescriber Signature

Prescriber, please sign and date below

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ **Date** _____ **Substitution Permissible** _____ **Date** _____

# of Prescriptions: _____

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.