

## Patient Information

(Please attach insurance card)

Name:		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____/_____/_____	
Street:		City	State:	Zip:
Phone:	Alt Phone:	Allergies:		

## Clinical Information

(Please attach all pertinent clinicals and lab results)

Diagnosis:  B20 HIV/AIDS  R64 Cachexia  Z20.6 Contact with and suspected exposure to HIV  Other \_\_\_\_\_

GFR \_\_\_\_\_ Date \_\_\_\_\_ CD4 Count \_\_\_\_\_ Date \_\_\_\_\_ Viral Load \_\_\_\_\_ Date \_\_\_\_\_

Previous Tried/Failed Medications: \_\_\_\_\_ Allergies \_\_\_\_\_ Weight: \_\_\_\_\_

## Prescription

Drug Therapy	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Atripla	600/200/300 mg	Take 1 tablet every day on an empty stomach		
<input type="checkbox"/> Biktarvy	50/200/25 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Combivir	150/300 mg	Take 1 tablet twice daily		
<input type="checkbox"/> Complera	200/25/300 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Delstrigo	100/300/300 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Descovy	200/25 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Dovato	50/300 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Epivir	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Take 150mg twice daily <input type="checkbox"/> Take 300mg daily		
<input type="checkbox"/> Epzicom	600/300 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Evotaz	300/150 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Genvoya	150/200/150/10	Take 1 tablet every day with food		
<input type="checkbox"/> Isentress	<input type="checkbox"/> 400mg <input type="checkbox"/> 600mg(HD)	<input type="checkbox"/> 1200mg once daily <input type="checkbox"/> 400mg twice daily		
<input type="checkbox"/> Juluca	50/25 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Norvir	100mg	Take 600mg twice daily with food		
<input type="checkbox"/> Odefsey	200/25/25 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Prezcobix	800/150 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg	<input type="checkbox"/> 150mg twice daily <input type="checkbox"/> 300mg twice daily <input type="checkbox"/> 600mg twice daily		
<input type="checkbox"/> Stribild	150/150/200/300 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Symfi	600/300/300 mg	Take 1 tablet every day on an empty stomach		
<input type="checkbox"/> Symfi Lo	400/300/300 mg	Take 1 tablet every day on an empty stomach		
<input type="checkbox"/> Symtuza	800/15/200/10 mg	Take 1 tablet every day with food		
<input type="checkbox"/> Tivicay	50mg	<input type="checkbox"/> 50mg once daily <input type="checkbox"/> 50mg twice daily		
<input type="checkbox"/> Triumeq	600/50/300 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Trizivir	300/150/300 mg	Take 1 tablet twice daily		
<input type="checkbox"/> Truvada	200/300 mg	Take 1 tablet every day with or without food		
<input type="checkbox"/> Zidovudine	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg	Take 300 mg twice daily		

## Prescriber information

Deliver To:  Patient  Office

Prescriber:		Supervising Physician:		
Contact Name:		Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email		
Phone:	Ext:	Fax:	Email:	
Street:		City:	State:	Zip:
Signature:		Date:	NPI	