ALLIED PHARMACY

HIV/AIDS

Ph: 832-365-3420 Fax: 855-595 -2955

MAIN POINT OF CONTACT

Name:_____

Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:

ID#: RxBin:

RxGroup:_____ Pcn:_____

Secondary Insurance:_____

ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

☐ Atripla	☐ Odefsey	☐ Descovy	☐ Zerit
☐ Biktarvy	☐ Stribild	☐ Emtriva	☐ Ziagen
☐ Cabenuva Injection Kit	☐ Symfi	☐ Epivir	☐ Zidovudine
☐ Complera	☐ Symfi Lo	☐ Epzicom	☐ Edurant
☐ Delstrigo	☐ Symtuza	☐ Retrovir	☐ Intelence
☐ Dovato	☐ Triumeq	☐ Trizivir	☐ Pifeltro
☐ Genvoya	☐ Cimduo	☐ Truvada	☐ Sustiva
☐ Juluca	☐ Combivir	☐ Viread	☐ Viramune

RX 1: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 2: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 3: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 4: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 5: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____ Date:_____**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

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RxGroup:_____ Pcn:_____

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Primary Diagnosis:_____ ICD10 Code:_____

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☐ Viramune XR	☐ Aptivus	☐ Reyataz	☐ Trogarzo
☐ Apretude Injection Kit	☐ Evotaz	☐ Viracept	
☐ Isentress	☐ Invirase	☐ Fuzeon	
☐ Isentress HD	☐ Kaletra	☐ Selzentry	
☐ Tivicay	☐ Lexiva	☐ Tybost	
☐ Tivicay PD	☐ Norvir	☐ Egrifta SV	
☐ Vocabria	☐ Prezcobix	☐ Egrifta WR	
	☐ Prezista	☐ Rukobia	

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Sig:_____

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RX 2: Drug Name/Strength:_____

Sig:_____

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Sig:_____

Qty:_____ Refills:_____

RX 4: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 5: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:_____ Zip Code:_____

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