Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

COREXA PHARMACY

HIV / AIDS Prescription Referral Form

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

1: Patient Information

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: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

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 ☐ tab ☐ 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 ☐ tab ☐ 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 ☐

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____