

### Patient Information

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State ZIP	
Temporary Address or Shipping Address (if different from above)				City		State ZIP	
Social Security Number		Date of Birth	Gender (M/F)	Weight	Height	Allergies	
Today's Date	Date Meds Needed	Emergency Contact/Phone			Primary Caregiver/Phone		

### Healthcare Provider Information: \*Indicates Required Field

Practice/Facility Name		Physician First and Last Name*		Phone*		Fax	
Address*				City*		State* ZIP*	
Physician NPI#*		Physician UPIN#		Physician DEA#		Physician State License #	
Nurse/Key Contact				Phone or Pager Number		Email	

### Diagnosis/Clinical Information: Please Fax a Copy of Patient's Insurance Card (Front and Back)

Diagnosis: ☐ 042 HIV/AIDS ☐ 079.53 HIV-2 ☐ 070.32 HBV (Chronic) ☐ 070.54 HCV (Chronic) New to current therapy? ☐ Yes ☐ No

CD4 Count: \_\_\_\_\_ Date: \_\_\_\_\_ HIV RNA: \_\_\_\_\_ Date: \_\_\_\_\_

Medication	Strength	Sig	Qty	Refills	Medication	Strength	Sig	Qty	Refills
<input type="checkbox"/> Aptivus®	250mg caps	Two capsules by mouth BID (Q 12 hours)			<input type="checkbox"/> Stribild®	150/150/200/300mg tabs	One tablet by mouth QD with food		
<input type="checkbox"/> Atripla®	600/300/200mg tabs	One tablet by mouth QD on an empty stomach			<input type="checkbox"/> Sustiva®	600mg tabs	Take one tablet at bedtime		
<input type="checkbox"/> Combivir®	150mg/300mg tabs	One tablet by mouth BID (Q 12 hours)			<input type="checkbox"/> Tivicay®	50mg tabs	Take _____ tabs _____ x daily		
<input type="checkbox"/> Complera®	200/25/300mg tabs	One tablet by mouth QD with food			<input type="checkbox"/> Trimeq®				
<input type="checkbox"/> Emtriva®	200mg caps	One capsule by mouth QD			<input type="checkbox"/> Trizivir®	300/150/300mg tabs	One tablet by mouth BID (Q 12 hours)		
<input type="checkbox"/> Epivir®	_____mg tabs	One tablet _____ x daily			<input type="checkbox"/> Truvada®	200mg/300mg tabs	One tablet by mouth QD		
<input type="checkbox"/> Epzicom®	600mg/300mg tabs	One tablet by mouth QD			<input type="checkbox"/> Viracept®				
<input type="checkbox"/> Invirase®					<input type="checkbox"/> Viramune®	200mg tabs			
<input type="checkbox"/> Isentress®	400mg tabs	One tablet by mouth BID (Q 12 hours)			<input type="checkbox"/> Viramune XR®	400mg tabs	One tablet by mouth QD		
<input type="checkbox"/> Kaletra®	200mg/50mg tabs	Take _____ tabs _____ x daily			<input type="checkbox"/> Viread®	300mg tabs	Take _____ daily		
<input type="checkbox"/> Norvir® caps	100mg caps	Take _____ caps _____ x daily			<input type="checkbox"/> Zerit®				
<input type="checkbox"/> Norvir® tabs	100mg tabs	Take _____ tabs _____ x daily			<input type="checkbox"/> Ziagen®	300mg tabs	Take _____ tabs _____ x daily		
<input type="checkbox"/> Prezista®	_____mg tabs	Take _____ tabs _____ x daily			<input type="checkbox"/>				
<input type="checkbox"/> Retrovir®	_____mg tabs	Take _____ tabs _____ x daily			<input type="checkbox"/>				
<input type="checkbox"/> Reyataz®	_____mg caps	Take _____ caps _____ x daily			<input type="checkbox"/>				
<input type="checkbox"/> Selzentry®	_____mg tabs	Take _____ tabs _____ x daily			<input type="checkbox"/>				

\*\*\*When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards\*\*\*

Physician Signature: \_\_\_\_\_ ☐ DAW (Dispense as Written) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize Tropicana Drugs and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.