

### PATIENT INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Allergies: \_\_\_\_\_ Ship to:  Patient  Clinic

### INSURANCE

Prescription Card: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ ID# \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_  
 Group: \_\_\_\_\_ ( Please attach copies of insurance cards. )

### DIAGNOSIS

B20 HIV  R64 Cachexia  B18.1 Hepatitis B  B18.2 Chronic HCV  HIV infected patients with Abdominal Lipodystrophy  Other  
 Prior failed medications: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
 Reason for DC: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

### LAB RESULTS

CD4 COUNT: \_\_\_\_\_ HIV RNA: \_\_\_\_\_ HGB/HCT: \_\_\_\_\_ SCR: \_\_\_\_\_ WBC/ANC: \_\_\_\_\_

### PRESCRIPTION INFORMATION

Medication	Dose	Directions	Qty.	Refill	Medication	Dose	Directions	Qty.	Refill
------------	------	------------	------	--------	------------	------	------------	------	--------

#### Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

Emtriva				
Epivir				
Retrovir				
Videx Ec				
Zerit				
Ziagen				

#### Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

Viread				
--------	--	--	--	--

#### Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

Endurant				
Intelence				
Rescriptor				
Sustiva				
Virammune				
Virammune Xr				

#### Protease Inhibitors (PIs)

Aptivus				
Crixivan				
Invirase				
Kaletra				
Lexiva				
Norvir				
Prezista				
Reyataz				
Viracept				

#### Integrase Strand Transfer Inhibitors (ISTIs)

Isentress				
Tivicay				
Viteka				

#### Entry Inhibitors (CCR5 Antagonists)

Fuzeon				
Salzentry				

#### Combination Antiretrovirals

Atripla				
Combivir				
Complera				
Descovy				
Epzicom				
Genvoya				
Prezcobix				
Stribild				
Triumeq				
Trizivir				
Truvada				

#### Other Medications


### PRESCRIBER INFORMATION

Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 State License#: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Office Contact Name /Number: \_\_\_\_\_  
 Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.  
 Confidentiality statement: this message is intended only for the individual or entity to which it is addressed. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws. If the reader of this form is not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information or copying this information. If you have received this communication in error, please notify us immediately by telephone.