



Today's Date _____ Needed by _____

Patient Demographics (please provide or attach)
Patient Name _____
Address _____
City, State, Zip _____
Home Phone _____ Alt Phone _____
DOB _____ Gender _____ Weight _____ BSA _____ m2

Prescriber (Please provide as much information as possible)
Prescriber's Name _____ Group/Hospital _____
NPI _____ DEA _____ Specialty _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Insurance Information (Please provide copy of insurance card front and back)
Primary Insurance _____ ID# _____ BIN# _____ PCN# _____ Phone _____

Medication Delivery (Please Chose Only One)

Patient Address First Fill Physician's Office, Refill to Patient Address Patient will pick up at Pharmacy

Diagnosis (ICD-10 code): B18.0 Chronic Hepatitis B with Delta Agent B18.1 Chronic Viral Hepatitis B without Delta Agent B18.2 Chronic Viral Hepatitis C

B20 HIV Disease R64 Cachexia Other Code: _____ Description: _____

Patient Clinical Information: Allergies: _____ Weight: _____ lbs./kg Height: _____ in/cm

Lab Results : Serum Creatinine _____ CD-4 Count _____ Viral Load _____ Date of Labs _____

Medication	Dose/Strength	Directions	Qty.	Ref.
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NRTIs				
<input type="checkbox"/> Emtriva *	<input type="checkbox"/> 10mg/mL <input type="checkbox"/> 200mg			
<input type="checkbox"/> EpiVir *	<input type="checkbox"/> 5mg/mL <input type="checkbox"/> 10mg/mL <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Retrovir *	<input type="checkbox"/> 50mg			
<input type="checkbox"/> Videx EC *	<input type="checkbox"/> 125mg <input type="checkbox"/> 200mg <input type="checkbox"/> 250mg <input type="checkbox"/> 400mg			
<input type="checkbox"/> Viread *	<input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 250mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Zerit *	<input type="checkbox"/> 40mg			
<input type="checkbox"/> Ziagen *	<input type="checkbox"/> 300mg			

NNRTIs				
<input type="checkbox"/> Edurant *	<input type="checkbox"/> 25mg			
<input type="checkbox"/> Intelence *	<input type="checkbox"/> 25mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg			
<input type="checkbox"/> Rescriptor *	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg			
<input type="checkbox"/> Sustiva *	<input type="checkbox"/> 50mg <input type="checkbox"/> 200mg <input type="checkbox"/> 600mg			
<input type="checkbox"/> Viramune XR *	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg			

Combination Antiretroviral				
<input type="checkbox"/> Atripla *	600mg/200mg/300mg			
<input type="checkbox"/> Combivir *	150mg/300mg			
<input type="checkbox"/> Complera *	200mg/25mg/300mg			
<input type="checkbox"/> Descovy *	200mg/25mg			
<input type="checkbox"/> Epzicom *	600mg/300mg			
<input type="checkbox"/> Genvoia *	150mg/200mg/150mg /10mg			
<input type="checkbox"/> Odefsey *	200mg/25mg/25mg			
<input type="checkbox"/> Prezobix *	800mg/150mg			
<input type="checkbox"/> Stribild *	150mg/150mg/200mg /300mg			

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____

Date _____ / _____ / _____

Medication	Dose/Strength	Directions	Qty.	Ref.
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Protease Inhibitors				
<input type="checkbox"/> Aptivus *	250mg			
<input type="checkbox"/> Crixivan *	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg			
<input type="checkbox"/> Evotaz™	<input type="checkbox"/> 300mg/150mg			
<input type="checkbox"/> Invirase *	<input type="checkbox"/> 500mg			
<input type="checkbox"/> Kaletra *	<input type="checkbox"/> 200mg/50mg <input type="checkbox"/> 100mg/25mg			
<input type="checkbox"/> Lexiva *	700mg			
<input type="checkbox"/> Norvir *	100mg			
<input type="checkbox"/> Prezista *	<input type="checkbox"/> 150mg <input type="checkbox"/> 600mg <input type="checkbox"/> 800mg			
<input type="checkbox"/> Reyataz *	<input type="checkbox"/> 50mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg			
<input type="checkbox"/> Viracept *	<input type="checkbox"/> 250mg <input type="checkbox"/> 625mg			

Entry Inhibitors				
<input type="checkbox"/> Fuzeon *	90mg vial			
<input type="checkbox"/> Selzentry *	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg			

Integrase Inhibitors				
<input type="checkbox"/> Isentress *	<input type="checkbox"/> 100mg <input type="checkbox"/> 400mg <input type="checkbox"/> 600mg			
<input type="checkbox"/> Tivicay *	50mg			
<input type="checkbox"/> Vitekta *	<input type="checkbox"/> 85mg <input type="checkbox"/> 150mg			

Other Medications				
<input type="checkbox"/> Bactrim *				
<input type="checkbox"/> Diflucan *				
<input type="checkbox"/> Egrifta *				
<input type="checkbox"/> Procrit *				
<input type="checkbox"/> Serostim *				
<input type="checkbox"/> Tybost *				

Supplements (Complimentary w/ Filled Rx)				
<input type="checkbox"/> Antioxidants				
<input type="checkbox"/> Magnesium				
<input type="checkbox"/> Selenium				
<input type="checkbox"/> Calcium				
<input type="checkbox"/> Vitamin D				
<input type="checkbox"/> Vitamin C				
<input type="checkbox"/> B Vitamins				
<input type="checkbox"/> Niacin				
<input type="checkbox"/> Other				