ONE CARE
infusion pharmacy

HIV/AIDS PRESCRIPTION

Phone: (505)726-4155 _____ Fax: (505)726-4304 _____

PATIENT

PatientName:_____ DOB:_____ SSN:_____
Address:_____ City:_____ St:_____ Zip:_____
Home Phone:( )_____ Cell( )_____ Work Phone: ( )_____

PHYSICIAN

MDName:_____ License:_____ DEA:_____ NPI:_____
Address:_____
_____ Phone:(_____)_____ Fax:(_____)_____ Contact:_____
_____

CLINICAL INFORMATION

Diagnosis:_____ ICD-10 Codes:_____ SerumCreatinine: _____

CD4 Count:_____ ViralLoad:_____ Date ofLabs:_____

PRESCRIPTION INFORMATION

ATRIPLA
tabs
Dispense 30 tabs
Take 1 tab daily on stomach
Refill:_____

EDURANT 25mg tabs
Dispense 30 tabs
Take 1 tab daily with
Refill:_____

ISENTRESS 400mg
tabs Dispense 60 tabs
Take 1 tab 2x
daily Refill:__

PREZISTA_____mgtabs
Dispense 1 month supply
Take_____tabs_____xdaily
Refill:_____

SEROSTIM_____mg
Inject_____mgSCdaily
Refill:_____

VIRAMUNE_____mgtabs
Dispense_____
Take_____tab___
_____xdaily Refill:

COMBIVIR
tabs
Dispense 60 tabs
Take 1 tab 2x daily
Refill:_____

EPIVIR mgtabs
Dispense 1 month supply
Take1tab xdaily
Refill:

KALETRA 200/50mg
tabs Dispense 120 tabs
Take_____tabs
_____daily Refill:

RESCRIPTOR 200mg
tabs Dispense 180 tabs
Take 2 tabs 3x daily

STRIBILD tablets
Take 1 tablet daily
Refill:_____

VIREAD 300mg tabs
Dispense__
_____tablets
Take_____daily
Refill;_____

COMPLERA
200mg/25mg/300mg
Dispense 1 month supply
Take 1 tab once daily
w/meal Refill:_

EPZICOM 600mg/300mg
tab Dispense 1 month
supply Take one tablet
daily
Refill:_____

LEXIVA 700mg tabs
Dispense 1 month supply
Take_____tabs
_____xdaily Refill:
_____

RETROVIR_____mgtabs
Dispense 1 month supply
Take____tabs___
_____xdaily Refill:
_____

SUSTIVA 600mg
tablets Dispense 30
tablets
Take 1 tab at
bedtime Refill:_

ZIAGEN 300mg
tabs Dispense 60
tabs
Take_____tabs_
_____xdaily Refill:
_____

EGRIFTA requires referral form. Please call Pharmacy for more information.

FUZEON 90mg injection
Dispense 1 kit
Inject 90mg SQ 2x daily
Refill:

MEPRON 750mg/5ml
____sachet
____suspension Dispense
_____daysupply
Take_____ml_____xdaily
Refill:
REYATAZ_____mgcaps
Dispense 1 month supply
Take_____caps___
_____xdaily Refill:

TRIZIVIR
300/150/300mg
tabs
Dispense 60 tabs
Refill:_____

ZITHROMAX 600mg tabs
Take_____tabs____xdaily
Take tabs
Refill:_____

EMTRIVA 200mg caps
Dispense 30 capsules
Take 1 cap once daily
Refill:_____

INTELENCE_____mgtabs
Dispense 1 month supply
Take tabs xdaily
Refill:

NORVIR 100mg tabs
Dispense 1 month supply
Take____tabs_____xdaily
Refill:_____

SELZENTRY mgtabs
Dispense 1 month
supply Take_____tabs
_____xdaily Refill:
_____

tabs
Dispense 30 tabs
Take 1 tab once
daily Refill:

OTHER:_____
_____
_____

Refill:_____

Physician Signature:_____ Date:_____

Physician Name:_____ NPI:_____

By signing above, the prescriber gives consent to both, the prescription(s) above, as well as to RX Biotech Specialty Pharmacy/Beverly Sinai Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.