GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: ___________

HIV / AIDS PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: ______________________________
Address: ______________________________
City, State,Zip: ______________________________

☐ Male ☐ Female
Date of Birth: ____________________
SSN: ____________________
Phone: ____________________

Need by Date: ________________
Ship to: ☐ Patient Home
☐ Other: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________

DEA: ____________________
Phone: ____________________
Contact Person: ____________________

NPI: ____________________
Fax: ____________________

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: ☐ ____________________ Diagnosis: ______________________________ Serum Creatinine: ____________________
CD4 Count: ____________________ Viral Load: ______________________________ Lab date: ____________________

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION STRENGTH		DIRECTION	QTY	REFILLS
☐ Atripla 600/300/200mg tab		Take 1 tablet daily on empty stomach	30d	
☐ Edurant 25mg tab	☐ Complera 200/25/300mg tab	Take 1 tablet daily with meal	30d	
☐ Stribild tab ☐ Truvada 200/300mg tab ☐ Sustiva 600mg tab (take at bedtime)	☐ Epzicom 600/300mg tab ☐ Emtriva 200mg tab	Take 1 tablet daily	30d	
☐ Isentress 400mg tab ☐ Trizivir 300/150/300mg tab	☐ Combivir 150/300mg tab	Take 1 tablet twice daily	30d	
☐ Prezista ________ mg tab ☐ Epivir __________ mg tab ☐ Intelence _______ mg tab ☐ Retrovir ________ mg tab ☐ Reyataz ________ mg tab ☐ Selzentry _______ mg tab	☐ Viramune _______ mg tab ☐ Kaletra 200/50mg tab ☐ Lexiva 700mg tab ☐ Ziagen 300mg tab ☐ Viread 300mg tab ☐ Norvir 100mg tab	☐ Take ______ tablets ____________ times per day	30d	
☐ Rescriptor 200mg tab		Take 2 tablets three times daily	180	
☐ Fuzeon 90mg Inj		Inject 90mg under skin twice daily	1 kit	
☐ Mepron 750mg/5ml suspension		Take _______ ml _________ time(s) a day		
☐ Zithromax 600mg tab		Take _______ tablets ______ ☐ daily ☐ weekly		

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer 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.

Prescriber Signature: ______________________________ **Date:** ____________________ ☐**Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: ______________________________ **Date:** ____________________

Important Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.