HIV PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ______ Middle Name ______ Last Name ______ DOB ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Daytime Tel ______ Evening Tel ______ Cell ______ Email ______
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed ______
ICD-10 Diagnosis ______ Allergies ______ CD4 ______ Viral Load ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______
Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg
Tabs | Sol # ____ Refill x ______ Sig ______
DESCOVY 200/25mg
Tabs # ____ Refill x ______ Sig ______
EMTRIVA 200mg
Caps # ____ Refill x ______ Sig ______
EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol # ____ Refill x ______ Sig ______
EPZICOM 600/300mg
Tabs # ____ Refill x ____ Sig ______
RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol # ____ Refill x ______ Sig ______
TRIZIVIR 300/150/300mg
Tabs | Sol # ____ Refill x ______ Sig ______
TRUVADA 200/300mg
Tabs | Sol # ____ Refill x ____ Sig ______
VIDEX EC 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd # ____ Refill x ____ Sig ______
VIREAD 300mg
Tabs | Sol # ____ Refill x ____ Sig ______
ZERIT
15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol # ____ Refill x ____ Sig ______
ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs | Sol # ____ Refill x ____ Sig ______

FUSION INHIBITORS

FUZEON 90mg Refill x ____ Sig ______

OTHER MEDICATIONS

ATRIPLA Tabs # ____ Refill x ____ Sig ______
COMPLERA Tabs # ____ Refill x ____ Sig ______
GENVOYA 150/150/200/10mg Tabs # ____ Refill x ____ Sig ______
ISENTRESS 400 mg Tabs # ____ Refill x ____ Sig ______
STRIBILD Tabs # ____ Refill x ____ Sig ______

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps # ____ Refill x ____ Sig ______
CRIXIVAN 200mg 333mg 400mg
Caps # ____ Refill x ____ Sig ______
EVOTAZ 300mg 150mg
Tabs # ____ Refill x ____ Sig ______
INVIRASE 200mg 500mg
Caps | Sol # ____ Refill x ____ Sig ______
KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol # ____ Refill x ____ Sig ______
LEXIVA 700mg Oral Susp. 50mg/ml
Tabs # ____ Refill x ____ Sig ______
NORVIR 100mg 80mg/ml
Caps | Sol # ____ Refill x ____ Sig ______
PREZCOBIX 800mg 150mg
Tabs # ____ Refill x ____ Sig ______
PREZISTA 75mg 150mg 400mg 600mg
Tabs | Sol # ____ Refill x ____ Sig ______
REYATAZ 100mg 150mg 200mg 300mg
Caps # ____ Refill x ____ Sig ______
VIRACEPT 250mg 625mg
Tabs | Pwd # ____ Refill x ____ Sig ______

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs # ____ Refill x ____ Sig ______
INTELENCE 100 mg 200mg
Tabs # ____ Refill x ____ Sig ______
RESCRIPTOR 200mg
Caps # ____ Refill x ____ Sig ______
SUSTIVA 50mg 200mg 600mg
Tabs | Caps # ____ Refill x ____ Sig ______
VIRAMUNE 200mg 50mg/5ml
Tabs | Sol # ____ Refill x ____ Sig ______

HGH

SEROSTIM ☐ 4mg ☐ 5mg ☐ 6mg Refill x ____ Sig ______

ADDITIONAL MEDICATIONS

Other ______ Tabs # ____ Refill x ____ Sig ______ Other ______ Tabs # ____ Refill x ____ Sig ______

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

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