HIV PRESCRIPTION FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 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 ____

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

STRIBILD Tabs #____ Refill x____ Sig ____
BIKTARVY Tabs #____ Refill x____ Sig ____
ATRIPLA Tabs #____ Refill x____ Sig ____
GENVOYA 150/150/200/10mg Tabs #____ Refill x____ Sig ____
COMPLERA Tabs #____ Refill x____ Sig ____
ISENTRESS 400 mg 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** ____