meijer specialty pharmacy

**P: 1-855-263-4537 • F: 1-877-222-5036**
**www.MeijerSpecialtyPharmacy.com**

# HIV

## Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

| | | | |
|---|---|---|---|
| Prescriber Name: | | ◯MD ◯DO ◯NP ◯PA | NPI: |
| Office Contact: | | Practice Name / Supervising MD: | |
| Address: | | City: | |
| State: | Zip: | Phone: | Fax: |

## Patient Information | PLEASE SEND COPY OF INSURANCE CARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient's Name: | Last 4 Digits of SS#: | DOB: / / | Sex: ◯ M ◯ F | Weight: | Height: | Diabetic: ◯ Y ◯ N |
| Address: | City: | State: | Zip: | Allergies: | | |
| Home Phone: | Work Or Cell: | HIPAA Contact: | Emergency #: | Interpreter Needed? ◯ Y ◯ N | | |

## Insurance Information

| | | | |
|---|---|---|---|
| Primary Insurance: | Policy ID: | Group #: | |
| Policyholder Name: | Policyholder DOB: | BIN: | PCN: |

## Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

| | | | | | |
|---|---|---|---|---|---|
| **ICD-10/Diagnosis Code:** ◯ B20 ◯ B21 ◯ B22 ◯ B23 ◯ B24 | ◯ HIV/AIDS Cachexia ◯ (HIV Wasting) | Date of Diagnosis: / / | Patient Weight: | BMI: | |
| CD4 / TCELL Count: | Viral Load (HIV RNA) | HGB / HCT: | White Blood Cell Count: | | |
| **TREATMENT ARRANGEMENTS:** | Ship Meds: ◯ Home ◯ Doctor's Office | PrEP Therapy: ◯ Y ◯ N | | | |

## Prescription Information

| | Medication | Dose/Strength | Sig | Qty | Refills |
|---|---|---|---|---|---|
| NNRTI'S | ◯ EDURANT® | | | | |
| | ◯ INTELENCE® | | | | |
| | ◯ SUSTIVA® | | | | |
| | ◯ VIRAMUNE® | | | | |
| COMBO/ARV'S | ◯ ATRIPLA® | | | | |
| | ◯ COMBIVIR® | | | | |
| | ◯ COMPLERA® | | | | |
| | ◯ DESCOVY® | | | | |
| | ◯ EPZICOM® | | | | |
| | ◯ EVOTAZ® | | | | |
| | ◯ GENVOYA® | | | | |
| | ◯ ODEFSEY® | | | | |
| | ◯ PREZOBIX® | | | | |
| | ◯ STRIBILD® | | | | |
| | ◯ TRIUMEQ® | | | | |
| | ◯ TRIZIVIR® | | | | |
| | ◯ TRUVADA® | | | | |

| | Medication | Dose/Strength | Sig | Qty | Refills |
|---|---|---|---|---|---|
| INTEGRASE INHIBITORS | ◯ ISENTRESS® | | | | |
| | ◯ TIVICAY® | | | | |
| NRTI'S | ◯ EMTRIVA® | | | | |
| | ◯ EPIVIR® | | | | |
| | ◯ RETROVIR® | | | | |
| | ◯ VIDEX® | | | | |
| | ◯ VIREAD® | | | | |
| | ◯ ZERIT® | | | | |
| | ◯ ZIAGEN® | | | | |
| PROTEASE INHIBITORS | ◯ CRIXIVAN® | | | | |
| | ◯ INVIRASE® | | | | |
| | ◯ KALETRA® | | | | |
| | ◯ LEXIVA® | | | | |
| | ◯ NORVIR® | | | | |
| | ◯ PREZISTA® | | | | |
| | ◯ REYATAZ® | | | | |
| | ◯ VIRACEPT® | | | | |

| ENTRY INHIBITORS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ◯ FUZEON® | | | | | | ◯ SELZENTRY® | | | | |

## Additional Instructions

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

| | |
|---|---|
| Physician Signature: Date | Physician Signature: Date |
| Substitution Permitted | Dispense as Written |