

www.pyramidspharmacy.com

All our referral forms are available on our website.

1: Patie	ent Information	·		·		
Patient Name: _		Birthdate:	Sex: Male Fe	male Height:	Weight:	□lbs. □kg.
Soc. Sec. #:	Pre	eferred Phone:	Known Allergies:			
Address:			City:		State: Zip	<u>:</u>
	Insurance Info	rmation: Please fax FRONT and BACK	copy of ALL Insurance ca	ards (Prescription and	Medical)	
Plan Name:		P	lan Phone:			
ID #:		Group #:	RxBIN:		RxPCN:	
2: Pres	criber Information					
Prescriber Name	e:		DEA#:	NPI#:	Tax ID#:	
			,		,	
City:		_ State: Zip: Ke	ey Contact:		Phone: ()	
📋 🗲 3: Diag	nosis/Clinical Information	on Please FAX recent clinical note	es, Labs, Tests, with the	prescription to exp	edite the Prior Authorizat	tion
Diagnosis (ICD-	<u>10)</u> :	New to current treatment: ☐ Yes ☐	□No			
☐ B20 Human In☐ Other:	nmunodeficiency Virus (HIV)	Has the patient been tested for:	1	Date of lab:		
_		Hep B: ☐ Yes ☐ No	 	HIV RNA:		
		Hep C: ☐ Yes ☐ No Test result:		Date of lab:		
4: Pres	cription Information					
Medication	Strength		Directions		Quantity	Refills
NRTIs:						
☐ Cimduo®	□ 300/300 mg tablet	☐ Take one tablet by mouth once☐ Other:	**	d.		
☐ Combivir®	☐ 150/300 mg tablet	☐ Take one tablet by mouth twice☐ Other:	•			
☐ Descovy®	□ 200/25 mg tablet	☐ Take one tablet by mouth once☐ Other:	e daily, with or without foo	d.		
D.F. I.	□ 200 mg capsule	☐ Take one capsule by mouth on☐ Other:	•			
□ Emtriva®	☐ 10 mg/mL solution	☐ Take 240 mg (24 mL) by mouth☐ Other:	once daily.			
□ Epivir®	☐ 150 mg tablet☐ 300 mg tablet☐ 10 mg/mL solution☐	☐ Take 150 mg by mouth twice d☐ Take 300 mg by mouth once d☐ Other:	,			
☐ Epzicom®	☐ 600/300 mg tablet	☐ Take one tablet by mouth once☐ Other:	e daily.			
☐ Retrovir®	☐ 100 mg capsule☐ 50mg/5 mL syrup	☐ Take mg by mouth☐ Other:	h time(s) daily.			
☐ Trizivir®	□ 300/150/300 mg tablet	☐ Take one tablet by mouth twice☐ Other:	e daily.			
☐ Truvada®	□ 100/150 mg tablet □ 133/200 mg tablet □ 167/250 mg tablet □ 200/300 mg tablet	☐ Take one tablet by mouth once☐ Other:	**			
Deliver to: □Pat	ient 🗆 Office 🗆 Other:		Date:	Nee	ds by Date:	
behalf as my authorized this prescription, I further	I agent, including the receipt of any required	ntatives to act as my authorized agent to secure cover prior authorization forms and the receipt and submiss formation and any related materials related to coverag	sion of patient lab values and other	patient data. In the event tha	t this pharmacy determines that it is	s unable to fulfill
		riber's Signature:			_ Date:	



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500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889,9964 | Fax: 1.888,383,2140

1: Patier	nt Information					
Patient Name:		Birthdate:				
Soc. Sec. #:	Pre	ferred Phone:	_			
Address:			City:		_ State: Zip: _	
	Insurance Infor	mation: Please fax FRONT and BAC	CK copy of ALL Insurance	cards (Prescription and M	Medical)	
Plan Name:			Plan Phone:			
ID #:		Group #:	RxBIN:	R	xPCN:	
2: Presc	riber Information					
			DEA#.	NDI#	Toy ID#	
		State: Zip:				
		on Please FAX recent clinical n				
Diagnosis (ICD-1 ☐ B20 Human Im	<u>ս</u> յ։ munodeficiency Virus (HIV)	New to current treatment: ☐ Yes	S U NO			
		Has the patient been tested for: Hep B: ☐ Yes ☐ No		I I		
	 	Hep C: ☐ Yes ☐ No				
	1	Test result:				
4: Presc	ription Information					
Medication	Strength		Directions		Quantity	Refills
☐ Videx EC®	☐ 125 mg capsule☐ 200 mg capsule☐ 250 mg capsule☐ 400 mg capsule☐ 400 mg capsule	☐ Take one capsule by mouth ☐ Other:				
□ Viread®	☐ 150 mg tablet☐ 200 mg tablet☐ 250 mg tablet☐ 300 mg tablet☐ 300 mg tablet☐ 40 mg/1 g powder	☐ Take one tablet by mouth on☐ Other:	•			
□ Zerit®	☐ 15 mg capsule ☐ 20 mg capsule ☐ 30 mg capsule ☐ 40 mg capsule ☐ 1 mg/mL solution	□ Take mg □ Other:	by mouth every 12 hours			
□ Ziagen®	□ 300 mg tablet	☐ Take 300 mg by mouth twice☐ Take 600 mg by mouth once☐ Other:	e daily.			
☐ Zidovudine	☐ 100 mg capsule☐ 300 mg tablet☐ 50 mg/5 mL syrup	☐ Take 300 mg by mouth twice☐ Take 200 mg by mouth three☐ Other:	e times daily.			
NNRTIs:						
☐ Edurant®	□ 25 mg tablet	☐ Take one tablet by mouth on☐ Other:				
☐ Intelence®	☐ 25 mg tablet☐ 100 mg tablet☐ 200	☐ Take 200 mg by mouth twice☐ Other:				
Deliver to: □Patie	ent Office Other:		Date:	Needs	s by Date:	
behalf as my authorized a this prescription, I further	igent, including the receipt of any required p	ratives to act as my authorized agent to secure co orior authorization forms and the receipt and subm ormation and any related materials related to cove Written	nission of patient lab values and otl	her patient data. In the event that the	nis pharmacy determines that it is u	nable to fulfill
		iber's Signature:				



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1: Patient Information						
		Birthdate:	Sev: Male Fo	emale Height	Weight:	□lhs □ka
		red Phone:		_	was	_
Address:			_		State: Zip: _	
	Insurance Informa	ation: Please fax FRONT and BACK copy	of ALL Insurance c	ards (Prescription and	l Medical)	
Plan Name:		Plan Pl			·	
ID #:		Group #:	RxBIN:		RxPCN:	
2: Prescriber Information						
			DEA#	ND!"	T 10"	
		State: Zip: Key Co	,		,	
Diagnosis (ICD-1		Please FAX recent clinical notes, La New to current treatment: □ Yes □ No	ads, resis, with the		euite the Phot Authorizatio	
	munodeficiency Virus (HIV)	Has the patient been tested for:	1			
☐ Other:		Hep B: ☐ Yes ☐ No		HIV RNA:		
	 	Hep C: ☐ Yes ☐ No Test result:	 			
	1	Test result.				
4: Presc	ription Information	Dire	ections		Quantity	Refills
	Strength	☐ Take one tablet by mouth once daily		od.	Quantity	Refills
☐ Pifeltro™	☐ 100 mg tablet	Other:	, with or without foc			
☐ 50 mg capsule☐ 200 mg capsule☐ 200 mg capsule☐ 200 mg capsule		☐ Take mg by mouth once daily on an empty stomach.				
a odoliva	☐ 600 mg tablet	Other:				
☐ Viramune XR®	☐ 100 mg tablet☐ 400 mg tablet	☐ Take mg by mouth once daily. ☐ Other:				
Single Tablet R	egimens:					
☐ Atripla®	□ 600/200/300 mg tablet	☐ Take one tablet by mouth once daily o☐ Other:			e.	
☐ Biktarvy®	□ 50/200/25 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	, with or without foc	od.		
☐ Complera®	□ 200/25/300 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	with food.			
☐ Delstrigo [™]	□ 100/300/300 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	, with or without foc	od.		
☐ Genvoya®	☐ 150/150/200/10 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	with food.			
☐ Juluca®	☐ 50/25 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	with a meal.			
☐ Odefsey®	□ 200/25/25 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	with a meal.			
☐ Stribild®	□ 150/150/200/300 mg tablet	☐ Take one tablet by mouth once daily☐ Other:	with a meal.			
Deliver to: Patient Office Other: Date: Needs by Date:						
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.						
□Product Substitution Permitted □Dispense as Written						
STAMP SIGNAT	URE NOT ALLOWED Prescribe	r's Signature:			_ Date:	



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1: Patie	nt Information					
Patient Name:		Birthdate:	Sex: Male I	Female Height:	Weight: [⊒lbs. □kg.
Soc. Sec. #:	Prefer	red Phone:	Known Allergie	es:		
Address:			City:		State: Zip: _	
	Insurance Inform	ation: Please fax FRONT and BACK	copy of ALL Insurance	cards (Prescription and Mo	edical)	
Plan Name:		Pl			·	
1		Group #:				
		·				
2: Preso	riber Information					
Prescriber Name:			DEA#:	NPI#:	Tax ID#:	
Address:			,		, ,	
City:		State:	y Contact:	P	hone: ()	·
3: Diagn	osis/Clinical Information	Please FAX recent clinical note	es, Labs, Tests, with t	he prescription to expedi	ite the Prior Authorization	n
Diagnosis (ICD-1	-	New to current treatment: ☐ Yes ☐	l No			
	munodeficiency Virus (HIV)	Has the patient been tested for:		Date of lab:		
		Hep B: □ Yes □ No Hep C: □ Yes □ No		HIV RNA:		
		Test result:		Date of lab:		
4. Presc	ription Information					
Medication	Strength		Directions		Quantity	Refills
☐ Symfi [™]	□ 600/300/300 mg tablet	☐ Take one tablet by mouth once d☐ Other:	aily on an empty stoma	ch, preferably at bedtime.		
☐ Symfi Lo™	□ 400/300/300 mg tablet	☐ Take one tablet by mouth once d☐ Other:	aily on an empty stoma	ch, preferably at bedtime.		
☐ Symtuza®	□ 800/150/200/10 mg tablet	☐ Take one tablet by mouth once daily with food. ☐ Other:				
☐ Triumeq®	□ 600/50/300 mg tablet	☐ Take one tablet by mouth once daily, with or without food. ☐ Other:				
Integrase Inhib	itors:					
☐ Isentress®	☐ 400 mg tablet	☐ Take one tablet (400 mg) by mo☐ Other:	uth twice daily.			
☐ Isentress HD®	□ 600 mg tablet	☐ Take 2 tablets (1200 mg) by mo☐ Other:				
□ Tivicay®	☐ 10 mg tablet☐ 25 mg tablet☐ 50 mg tablet☐	☐ Take one tablet (50 mg) by mou☐ Other:		,		
Protease Inhib	itors:					
☐ Evotaz®	☐ 300/150 mg tablet	☐ Take one tablet by mouth once☐ Other:				
☐ Kaletra®	☐ 200/50 mg tablet☐ 100/25 mg tablet	☐ Take tablets by mout ☐ Other:	th daily.			
□ Lexiva®	□ 700 mg tablet	☐ Take two tablets (1,400 mg) by once daily. ☐ Other:	mouth once daily with			
Deliver to: Patient Office Other: Date: Needs by Date:						
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.						
	ution Permitted Dispense as W					
STAMP SIGNAT	URE NOT ALLOWED Prescribe	er's Signature:			Date:	



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1: Patient Information							
		Rirthdate	Sex: Male Female Height:	Weight: □lbe □kg			
		erred Phone:					
Address:			City:				
	Insurance Inform	nation: Please fax FBONT and BACK conv	y of ALL Insurance cards (Prescription and Mec	lical)			
Plan Name:			Phone:				
1			RxBIN: RxP0				
2: Preso	riber Information						
			DEA#. ND#.	TID#-			
			DEA#: NPI#: Fhone: () F				
City:			ontact: Pho	,			
Diagnosis (ICD-1		New to current treatment: ☐ Yes ☐ No	abs, Tests, with the prescription to expedite	the Prior Authorization			
	munodeficiency Virus (HIV)						
Other:		Has the patient been tested for: Hep B: ☐ Yes ☐ No	1111/ 5346				
		Hep C: ☐ Yes ☐ No					
	1	Test result:					
4: Presc	ription Information						
Medication	Strength	Di	rections	Quantity Refills			
☐ Prezcobix®	□ 800/150 mg tablet	☐ Take one tablet by mouth once daily v☐ Other:	with food.				
	☐ 75 mg tablet☐ 150 mg tablet		h 100 mg ritonavir daily with food n 150 mg cobicistat daily with food				
☐ Prezista®	☐ 600 mg tablet	☐ Other:		•			
	□ 800 mg tablet	<u>`</u>	t ritonavir or cobicistat on form)				
☐ Reyataz®	☐ 150 mg capsule☐ 200 mg capsule	□ Take 300 mg by mouth with 100 mg ritonavir once daily with food □ Take 300 mg by mouth with 150 mg cobicistat once daily with food					
□ Fleyata2	☐ 300 mg capsule	Other:(Note: Please also select					
	☐ 250 mg tablet	☐ Take 1250 mg by mouth twice daily w					
☐ Viracept®	☐ 625 mg tablet	☐ Take 750 mg by mouth three times da☐ Other:	aily with a meal.				
Pharmacokine	tic Enhancers:						
☐ Norvir®	☐ 100 mg tablet						
☐ Tybost®	☐ 150 mg tablet						
Entry Inhibitors:							
☐ Fuzeon®	☐ 90 mg Vial Kit	☐ Inject 90 mg (1 mL) subQ twice daily.☐ Other:					
	☐ 25 mg tablet						
☐ Selzentry®	☐ 75 mg tablet☐ 150 mg tablet	☐ Take mg by mouth	h twice daily, with or without food.				
2 00.20,	□ 300 mg tablet	Other:					
□ 20mg/mL solution							
Deliver to:							
*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.							
□Product Substitution Permitted □Dispense as Written							
STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: Date:							