HIV / AIDS Prescription Referral Form

PYRAMIDS PHARMACY

www.pyramidspharmacy.com

All our referral forms available on our website.

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Houston, Texas, 77079
Toll Free Phone: (877) 866-9579
Toll Free Fax: (877) 866-9578

☐ 500 Kobayashi Rd ste E
Webster, TX ,77598
Toll Free Phone: (855) 339-1931
Toll Free Fax: (855) 339-1930

Date Medication Needed: _____ **Ship To:** Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** ☐ Male ☑ Female **Height:** _____ **Weight:** _____ ☐ lbs. ☐ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

_____ _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** (_____) _____ - _____ **Fax:** (_____) _____ - _____

City: _____ **State:** _____ **Zip:** _____ **Key Contact:** _____ **Phone:** (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ **ICD-9:** _____ **Serum Creatinine:** _____

CD4 Count: _____ **Viral Load:** _____ **Date of labs:** _____

4: Prescription Information

Atripla® 600/300/200mg tabs Dispense 30 tabs Take 1 tab daily on empty stomach Refill X	Combivir® 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X	Complera® 200mg/25mg/300mg Dispense 1 month supply Take 1 tab once daily w/ meal Refill X	Egrifta® requires specific referral form. Please use Serono Egrifta Statement of Medical Necessity form.	Emtriva® 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X
Edurant® 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X	Epivir® mg tabs Dispense 1 month supply Take 1 tab X daily Refill X	Epzicom® 600mg/300mg tabs Dispense 1 month supply Take one tablet daily Refill X	Fuzeon® 90mg Inj Dispense 1 kit Inject 90mg under skin 2x daily Refill X	Intelence® mg tabs Dispense 1 month supply Take tabs X daily Refill X
Isentress® 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X	Kaletra® 200/50mg tabs Dispense 120 tabs Take tabs X daily Refill X	Lexiva® 700mg tabs Dispense 1 month supply Take tabs X daily Refill X	Mepron® 750mg/5ml ☐ sachet ☐ suspension Dispense day supply Take ml X daily Refill X	Norvir® 100mg tabs Dispense 1 month supply Take tabs X daily Refill X
Prezista® mg tabs Dispense 1 month supply Take tabs X daily Refill X	Rescriptor® 200mg tabs Dispense 180 tabs Take 2 tabs 3X daily Refill X	Retrovir® mg tabs Dispense 1 month supply Take tabs X daily Refill X	Reyataz® mg caps Dispense 1 month supply Take caps X daily Refill X	Selzentry® mg tabs Dispense 1 month supply Take tabs X daily Refill X
Serostim® mg Inject mg SC daily Refill X	Stribild™ tablets Take 1 tablet daily Refill X	Sustiva® 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X	Trizivir® 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X	Truvada® 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X
Viramune® mg tabs Dispense Take tab X daily Refill X	Viread® 300mg tabs Dispense tablets Take daily Refill X	Ziagen® 300mg tabs Dispense 60 tabs Take tab X daily Refill X	Zithromax® 600mg tabs Take tabs X daily Take tabs X weekly Refill X	Other: ☐ Refill X

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

# of Prescriptions: _____