Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

SCRIPX | HIV / AIDS Prescription Referral Form

Send your Rx to: | Choose Location

www.ScripX.com
If you have questions or concerns, please contact us.

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

Provider Name: _____ **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-10:** _____ **Serum Creatinine:** _____

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

PrEP: _____

4: Prescription Information

☐ Aptivus®	☐ Genvoya®	☐ Selzentry®	☐ _____
☐ Atripla®	☐ Intelence®	☐ Stribild®	☐ _____
☐ Biktarvy®	☐ Invirase®	☐ Sustiva®	☐ _____
☐ Combivir®	☐ Isentress®	☐ Tivicay®	☐ _____
☐ Complera®	☐ Juluca®	☐ Triumeq®	☐ _____
☐ Descovy®	☐ Kaletra®	☐ Trizivir®	☐ _____
☐ Edurant®	☐ Lexiva®	☐ Truvada®	☐ _____
☐ Emtriva®	☐ Norvir®	☐ VALCYTE®	
☐ Epivir®	☐ Odefsey®	☐ Viramune®	
☐ Epzicom®	☐ Prezcobix®	☐ Viread®	
☐ Evotaz®	☐ Prezista®	☐ Vitekta®	
☐ Fuzeon®	☐ Reyataz®	☐ Ziagen®	

STRENGTH/DIRECTIONS (SIG): _____ Qty: _____ Refills: _____

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STRENGTH/DIRECTIONS (SIG): _____ Qty: _____ Refills: _____

STRENGTH/DIRECTIONS (SIG): _____ Qty: _____ Refills: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written | Date | Substitution Permissable | Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____