PARK AVENUE PHARMACY

SPECIALTY CARE SOLUTIONS

HIV / AIDS Rx Referral Form

3712 Park Ave. Weehawken, NJ 07086 Info@parkaverx.com www.parkaverx.com
Phone: (201)552-9500 Fax:(888)332-4494 E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Or Pick-up from Pharmacy

Injection needed by pharmacy? ☐ Yes ☐ No

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

Diagnosis ICD-10: ☐ B20 HIV ☐ B18.0 HBV with delta agent (Chronic) ☐ B18.1 HBV without delta agent (Chronic) ☐ B18.2 HCV (Chronic)

New to current therapy? ☐ yes ☐ no CD4: _____ date: _____ HIV RNA: _____ date: _____

3: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

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

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

4: Prescription Information

Medication	QTY	Refills	Medication	QTY	Refills
☐ Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)			☐ Retrovir® (zidovudine)		
☐ Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empy stomach			☐ Reyataz® (atazanavir)		
☐ Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)			☐ Selzentry® (maraviroc)		
☐ Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food			☐ Stribid™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
☐ Crixivan® (indinavir) One tablet by mouth QD with a meal			☐ Sustiva® (efavirenz)		
☐ Edurant™ (rilpivirine) 25 mg One capsule by mouth QD			☐ Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
☐ Emtrivia® (emtricitabine) 200 mg			☐ Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
☐ Epivir® (lamivudine)			☐ Videx® EC (didanosine)		
☐ Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD			☐ Viracept® (nelfinavir		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			☐ Viramune® (nevirapine) 200 mg		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			☐ Viramune® XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
☐ Intelence® (entravirine)			☐ Viread® (tenofovir) 300 mg		
☐ Invirase® (saquinavir)			☐ Zerit® (stavudine)		
☐ Isentress® (raltegravir) 400 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			☐ Ziagen® (avacavir) 300 mg		
☐ Kaletra® (lopinavir/ritonavir) 200/50 mg			**other medications**		
☐ Lexiva® (fosamprenavir) 200/50 mg			☐ Acylovir		
☐ Norvir® (ritonavir) capsules 100 mg			☐ Bactrim® (TMC/SMZ)		
☐ Norvir® (ritonavir) tablets 100 mg			☐ Bactrim® DS(TMP/SMZ)		
☐ Prezista® (darunavir)			☐ Dapsone		
☐ Rescriptor® (delavirdine)			☐ Diflucan® (fluconazole)		
			☐ Serostim® (somatropin		
			☐ Valtrex® (valacyclovir)		
			☐ Zithromax® (azithromycin)		

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

Patient Signature: _____ Date: _____

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable _____ Date _____ Dispense as written _____ Date _____