HIV / AIDS REFERRAL FORM

Jersey Shore Pharmacy
580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name_____ Date of Birth_____
☐ Male ☐ Female SS#_____ Language_____
Address_____ Apt #_____
City_____ State_____ ZIP_____
Phone_____ Cell_____ Email_____
Allergies_____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name_____
Relation to Patient_____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare#_____
Prescription Card ☐ Yes ☐ No If Yes, Carrier_____
Phone_____ Fax_____
Policy/Group#_____
Bin#_____ Pcn#_____
RXID#_____ RX Group#_____

ICD-10: ☐ B20 HIV/AIDS ☐ R64 Cachexia (HIV Wasting) ☐ B18.2 Hepatitis C (chronic) ☐ B18.1 Hepatitis B
☐ HIV-Infected patients with abdominal lipodystrophy ☐ Other _____
CD4 count_____ Viral Load/HIV RNA_____ Hgb/Hct_____ WBC/ANC_____ CrCl_____ (Please include copy of most recent labs)

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg
Tabs #_____ Refill:_____ Sig:_____

EMTRIVA 200mg 10mg/ml
Caps|Sol #_____ Refill:_____ Sig:_____

EPIVIR 150mg 300mg 10mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

EPZICOM 600/300mg
Tabs #_____ Refill:_____ Sig:_____

RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

TRIZIVIR 300/150/300mg
Tabs #_____ Refill:_____ Sig:_____

TRUVADA 200/300mg
Tabs #_____ Refill:_____ Sig:_____

VIDEXEC 125mg 200mg 250mg 400mg
Plain Videx Solution 10mg/ml
Tabs|Pwd #_____ Refill:_____ Sig:_____

VIREAD 150mg 200mg 250mg 300mg
Tabs #_____ Refill:_____ Sig:_____

ZERIT
15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps|Sol #_____ Refill:_____ Sig:_____

ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

FUSION INHIBITORS

FUZEON 90mg Refill:_____ Sig:_____

OTHER MEDICATIONS

ATRIPLA Tabs #_____ Refill:_____ Sig:_____
COMPLERA Tabs #_____ Refill:_____ Sig:_____
ISENTRESS 400 mg Tabs #_____ Refill:_____ Sig:_____
ODEFSEY Tabs #_____ Refill:_____ Sig:_____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps|Sol #_____ Refill:_____ Sig:_____

CRIXIVAN 400mg
Caps #_____ Refill:_____ Sig:_____

EVOTAZ 300mg 150mg
Tabs #_____ Refill:_____ Sig:_____

INVIRASE 200mg 500mg
Caps #_____ Refill:_____ Sig:_____

KALETRA 100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs|Sol #_____ Refill:_____ Sig:_____

LEXIVA 700mg Oral Susp. 50mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

NORVIR 100mg 80mg/ml
Caps|Sol #_____ Refill:_____ Sig:_____

PREZCOBIX 800mg 150mg
Tabs #_____ Refill:_____ Sig:_____

PREZISTA 75mg 150mg 400mg 600mg 100mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

REYATAZ 100mg 150mg 200mg 300mg
Caps #_____ Refill:_____ Sig:_____

VIRACEPT 250mg 625mg
Tabs|Pwd #_____ Refill:_____ Sig:_____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs #_____ Refill:_____ Sig:_____

INTELENCE 100 mg 200mg
Tabs #_____ Refill:_____ Sig:_____

RESCRIPTOR 100 mg 200mg
Caps #_____ Refill:_____ Sig:_____

SUSTIVA 50mg 200mg 600mg
Tabs|Caps #_____ Refill:_____ Sig:_____

VIRAMUNE 200mg 50mg/5ml 400mg/ml
Tabs|Sol #_____ Refill:_____ Sig:_____

OTHER

_____ QTY:_____ Refill:_____
Sig:_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ ZIP_____
Phone _____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date**_____

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.