



Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION Deliver Here

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: Male Female

Email: _____

Last 4# of SS: _____

PRESCRIBER INFORMATION Deliver Here

Name: _____

State License #: _____ NPI: _____

DEA #: _____ Tax ID _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

Diagnosis: Primary ICD-10 _____ Other ICD-10 _____

Medication	Strength	Directions	Quantity	Refills	Medication	Strength	Directions	Quantity	Refills
COMBINATION ANTIRETROVIRALS					PROTEASE INHIBITORS				
<input type="checkbox"/> ATRIPLA	300/200/600mg				<input type="checkbox"/> APTIVUS				
<input type="checkbox"/> COMBIVIR	300/150mg				<input type="checkbox"/> CRIVIVAN				
<input type="checkbox"/> COMPLERA	300/200/50mg				<input type="checkbox"/> INVIRASE				
<input type="checkbox"/> EPZICOM	600/300mg				<input type="checkbox"/> KALETRA				
<input type="checkbox"/> STRIBILD	150/150/200/300mg				<input type="checkbox"/> LEXIVA				
<input type="checkbox"/> TRIZIVIR	300/150/300mg				<input type="checkbox"/> NORVIR Tabs	100mg			
<input type="checkbox"/> TRUVADA	300/200mg				<input type="checkbox"/> NORVIR Caps	100mg			
<input type="checkbox"/> TRIUMEQ	50/600/300mg				<input type="checkbox"/> PREZISTA				
<input type="checkbox"/> GENVOYA	150/150/200/10mg				<input type="checkbox"/> REYATAZ				
<input type="checkbox"/> ODEFSEY	200/25/200mg				<input type="checkbox"/> VIRACEPT				
<input type="checkbox"/> DESCOVY	200/25mg				INTEGRASE INHIBITORS				
					<input type="checkbox"/> ISENTRESS				
					<input type="checkbox"/> TIVICAY				
					ENTRY/FUSION INHIBITORS				
					<input type="checkbox"/> FUZEON	90mg Vial			
					<input type="checkbox"/> SELZENTRY				
NNRTIs					NRTIs				
<input type="checkbox"/> EDURANT	25mg				<input type="checkbox"/> EMTRIVA				
<input type="checkbox"/> INETELANCE					<input type="checkbox"/> EPIVIR				
<input type="checkbox"/> RESCRIPTOR					<input type="checkbox"/> RETROVIR				
<input type="checkbox"/> SUSTIVA					<input type="checkbox"/> VIDEX				
<input type="checkbox"/> VIRAMUNE					<input type="checkbox"/> VIREAD				
<input type="checkbox"/> VIRAMUNE XR	400mg				<input type="checkbox"/> ZERIT				
					<input type="checkbox"/> ZIAGEN				

Today's Date _____ Date Needed: _____

Ship to: Patient Physician Other: _____

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: _____ Date: _____

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. **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. Pursuant to VA/OH/MOVT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289

3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

