

# LINCOLN PHARMACY

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Date: \_\_\_\_\_

## HIV / AIDS PRESCRIPTION FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ SSN: \_\_\_\_\_  
Phone: \_\_\_\_\_

Need by Date: \_\_\_\_\_  
Ship to:  Patient Home  
 Other: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Contact Person: \_\_\_\_\_

### DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code:  \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Serum Creatinine: \_\_\_\_\_  
CD4 Count: \_\_\_\_\_ Viral Load: \_\_\_\_\_ Lab date: \_\_\_\_\_

### PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION  PREVIOUSLY DISPENSED

### MEDICATIONS

MEDICATION STRENGTH	DIRECTION	QTY	REFILLS
<input type="checkbox"/> Atripla 600/300/200mg tab	Take 1 tablet daily on empty stomach	30d	
<input type="checkbox"/> Edurant 25mg tab <input type="checkbox"/> Complera 200/25/300mg tab	Take 1 tablet daily with meal	30d	
<input type="checkbox"/> Stribild tab <input type="checkbox"/> Epzicom 600/300mg tab <input type="checkbox"/> Truvada 200/300mg tab <input type="checkbox"/> Emtriva 200mg tab <input type="checkbox"/> Sustiva 600mg tab (take at bedtime)	Take 1 tablet daily	30d	
<input type="checkbox"/> Isentress 400mg tab <input type="checkbox"/> Combivir 150/300mg tab <input type="checkbox"/> Trizivir 300/150/300mg tab	Take 1 tablet twice daily	30d	
<input type="checkbox"/> Prezista _____ mg tab <input type="checkbox"/> Viramune _____ mg tab <input type="checkbox"/> Epivir _____ mg tab <input type="checkbox"/> Kaletra 200/50mg tab <input type="checkbox"/> Intelence _____ mg tab <input type="checkbox"/> Lexiva 700mg tab <input type="checkbox"/> Retrovir _____ mg tab <input type="checkbox"/> Ziagen 300mg tab <input type="checkbox"/> Reyataz _____ mg tab <input type="checkbox"/> Viread 300mg tab <input type="checkbox"/> Selzentry _____ mg tab <input type="checkbox"/> Norvir 100mg tab	<input type="checkbox"/> Take _____ tablets _____ times per day	30d	
<input type="checkbox"/> Rescriptor 200mg tab	Take 2 tablets three times daily	180	
<input type="checkbox"/> Fuzeon 90mg Inj	Inject 90mg under skin twice daily	1 kit	
<input type="checkbox"/> Mepron 750mg/5ml suspension	Take _____ ml _____ time(s) a day		
<input type="checkbox"/> Zithromax 600mg tab	Take _____ tablets _____ <input type="checkbox"/> daily <input type="checkbox"/> weekly		

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  Do not substitute

### Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important Notice:** This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.