HIV / Infectious Disease

Fax Referral to: 512-487-5033 Phone: 512-432-5190
Email Referral to: april@martinsspecialtypharmacy.com

Patient Information		Prescriber Information		
Patient Name		Prescriber Name		
Address		DEA#	NPI#	License #
City, State, Zip		Address		
Primary Phone	Emergency Contact Name & Phone Number	City, State, Zip		
Date of Birth	☐ Male ☐ Female	Phone	Fax	
Social Security #		Contact Person		

Insurance Information: Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information:

Please fax recent clinical notes, labs and tests with this prescription to expedite the Prior Authorization

Diagnosis: ☐ B20 HIV/AIDS ☐ B97.35 HIV-2 ☐ Other: ICD code ________ Condition: ________
☐ R64 Cachexia (HIV Wasting) ☐ B18.1 Chronic Hepatitis B ☐ B18.2 Chronic Hepatitis C

CD4/T-cell: ________ Date: ________ HIV RNA: ________ Date: ________ HCV Genotype: ________

Viral Load: ________ Last Blood Draw Date: ________ Hgb/Hct: ________ WBC: ________ CrCl: ________

Allergies: ________ Height: ________ Weight: ________

Prescription Information

Medication	Strength	Directions	Quantity	Refills
NRTIs / NNRTIs				
☐ Edurant®	25mg Tablets	1 tablet QD with meal	30 Tablets	____
☐ Emtriva®	200mg Capsules	1 capsule daily	30 Capsules	____
☐ Epivir®			1 month supply	____
☐ Intelence®			1 month supply	____
☐ Resciptor®			1 month supply	____
☐ Retrovir®			1 month supply	____
☐ Sustiva®			1 month supply	____
☐ Videx®			1 month supply	____
☐ Videx EC®			1 month supply	____
☐ Viramune®			1 month supply	____
☐ Viramune XR®			1 month supply	____
☐ Viread®	300mg Tablets	1 tablet daily	30 Tablets	____
☐ Zerit®			1 month supply	____
☐ Ziagen®	300mg Tablets		1 month supply	____
Combinations				
☐ Atripla®	600/300/200mg	1 tablet QD empty stomach	30 Tablets	____
☐ Combivir®	150/300mg Tabs	1 tablet BID (q12hrs)	60 Tablets	____
☐ Complera®	200/25/300mg	1 tablet QD with meal	30 Tablets	____
☐ Epzicom®	600/300mg Tabs	1 tablet daily	30 Tablets	____
☐ Stribild®	150/150/200/300	1 tablet QD with meal	30 Tablets	____
☐ Trizivir®	300/150/300mg	1 tablet BID (q12hrs)	60 Tablets	____
☐ Truvada®	200/300mg Tabs	1 tablet daily	30 Tablets	____

Medication	Strength	Directions	Quantity	Refills
Integrase Inhibitors				
☐ Isentress®	400mg Tablets	1 tablet BID (q12hrs)	60 Tablets	____
☐ Selzentry®			1 month supply	____
☐ Tivicay®	50mg Tablets		1 month supply	____
Protease Inhibitors				
☐ Aptivus®	250mg Capsules	2 capsules BID	120 Capsules	____
☐ Crixivan®			1 month supply	____
☐ Invirase®			1 month supply	____
☐ Kaletra®	200/50mg Tabs		1 month supply	____
☐ Lexiva®	700mg Tablets		1 month supply	____
☐ Norvir®	100mg Tablets		1 month supply	____
☐ Prezista®			1 month supply	____
☐ Reyataz®			1 month supply	____
☐ Viracept®			1 month supply	____
Other Medications				
☐ Genvoya®	150/150/200/10mg	1 tablet QD with food	30 Tablets	____
Urine Glucose: ________ Urine Protein: ________				
Tested for Hep-B infection: ☐ Yes ☐ No Date: ________				
☐				____
☐				____
☐				____
☐				____
☐				____

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW ________ Date

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.