HIV
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

ACHC ACCREDITED HEALTHCARE COMPANY — urac ACCREDITED Specialty Pharmacy Expires 01/01/2020

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

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

Diagnosis:	ICD 10:

4. Prescription Information: For IV medications attach a copy of your prescription

☐ **Aptivus®** 250mg caps Dispense 1-month supply Take 2 caps 2X daily Refill X _____	☐ **Atripla®** 600/200/300mg tabs Dispense 30 tabs Take 1 tab QD on empty stomach Refill X _____	☐ **Combivir®** 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____	☐ **Complera** 200mg/25mg/300mg tabs Dispense 1-month supply Take 1 tab once daily w/ meal Refill X _____	☐ **Emtriva®** 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X _____
☐ **Edurant®** 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X _____	☐ **Epivir®** ☐ 300mg tabs ☐ 600mg tabs Dispense 1-month supply Take _____ caps _____ X daily Refill X _____	☐ **Epzicom®** 600mg/300mg tabs Dispense 1-month supply Take 1 tab daily Refill X _____	☐ **Evotaz** 300/150mg tabs Dispense 30 tablets Take 1 tab QD with a light meal Refill X _____	☐ **Fuzeon®** 90mg Inj (1mL) Dispense 1 kit Inject 90mg under skin 2x daily Refill X _____
☐ **Genvoya®** 150/150/200/10mg tabs Dispense 30 tabs Take 1 tab daily with food Refill X _____	☐ **Intelence®** 200 mg tabs Dispense 1-month supply Take 1 tab 2X daily following meal Refill X _____	☐ **Isentress®** 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____	☐ **Kaletra®** ☐ 200/50mg tabs ☐ 100/25mg tabs Dispense 120 tabs Take _____ tabs _____ X daily Refill X _____	☐ **Lexiva®** 700mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____
☐ **Mepron®** 750mg/5ml ☐ **sachet** ☐ **suspension** Dispense _____ day supply Take _____ ml _____ X daily Refill X _____	☐ **Norvir®** 100mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	☐ **Odefsey™** 200mg/25mg/25mg tabs Dispense 30 tabs Take 1 tab daily with food Refill X _____	☐ **Prezcobix** 800/150mg tabs Dispense 30 tablets Take 1 tab daily with food Refill X _____	☐ **Prezista®** _____ mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____
☐ **Rescriptor®** 200mg caps Dispense 180 capsules Take 2 caps 3X daily Refill X _____	☐ **Retrovir®** 300 mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	☐ **Reyataz®** _____ mg caps Dispense 1-month supply Take _____ caps _____ X daily Refill X _____	☐ **Selzentry®** _____ mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	☐ **Serostim®** _____ mg Dispense 1-month supply Inject _____ mg SC daily Refill X _____
☐ **Stribild™** 150mg/150mg/200mg/300mg) tablets Dispense 1-month supply Take 1 tablet daily with food Refill X _____	☐ **Sustiva®** 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X _____	☐ **Tivicay** 50mg tabs Dispense 1-month supply Take 1 tablet _____ X daily Refill X _____	☐ **Triumeq®** 600/50/300mg tabs Dispense 30 tablets Take 1 tablet by mouth daily with or without food Refill X _____	☐ **Trizivir®** 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____
☐ **Truvada®** 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X _____	☐ **Tybost** 150mg tabs Dispense 30 tabs Take 1 tab daily Refill X _____	☐ **Viramune®** 200mg tabs Dispense _____ tabs Take 1 tab _____ X daily Refill X _____	☐ **Viread®** 300mg tabs Dispense _____ tablets Take once daily Refill X _____	☐ **Vitekta** _____ mg tabs Dispense 1-month supply Take 1 tab daily Refill X _____
☐ **Ziagen®** ☐ 300mg tabs ☐ 600mg tabs Dispense _____ tabs Take _____ tabs _____ X daily Refill X _____	☐ **Zerit®** _____ mg caps Dispense 1-month supply Take _____ mg every 12 hours Refill X _____	**Other:** _____ _____ Refill X _____	**Other:** _____ _____ Refill X _____	**Other:** _____ _____ Refill X _____

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.