Star Discount Pharmacy specialty care

urac ACCREDITED Specialty Pharmacy Expires 12/01/2021

ACHC

Human Immunodeficiency Virus

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name:______________________ DOB:__________ Gender: OM OF

Address: ______________________________________ City: ______________ State: _____ Zip: __________

Phone: ____________________ Alt. Phone: __________ Email: ______________________ Ht: _____ Wt: _____

Care Giver: ____________________ Allergies: ○ No Known ○ See Attached Charts Other: ____________________

Please include front and back copies of insurance card

Prescriber Information

Name: ________________________ NPI: ____________ Phone: ____________ Fax: ____________

Address: _________________________ City: __________ State:____ Zip:________ Office Contact: __________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: __________ ICD-10: __________________ Contraindications: ○Yes ○No

Blood Results:

Date Drawn: ________

Hgb/Hct: __________ WBC: ____________

Patient Training: ○ Pharmacist to Provide Training
○ Patient Trained in MD Office ○ Manufacturer Nurse Support

Product Delivery: ○Patient's Home ○Physician's Office
○ Pharmacy to Coordinate

Prescription Information:

Test/Procedure	Date Performed	Results
HIV-		○ Positive ○ Negative
CD/4/T-cell		
HIV RNA		
Viral Load		
Liver Biopsy		

Prescription Information:

Medication				Dosage & Strength/Directions	Qty	Ref
NRTIs/NNRTIs						
Descovy 200/25 PrEP Adult Treatment Pediatric Treatment	**Edurant** 25mg **Emtriva** **Epivir** **Intelence** **Rescriptor**	**Retrovir** **Sustiva** **Videx** **Viramune** **Viramune XR**	**Viread** **Zerit** **Ziagen**			
Protease Inhibitors						
Aptivus 250mg **Crixivan** **Evotaz** 300/150mg	**Invirase** **Kaletra** **Lexiva**	**Norvir** **Prezista** **Reyataz**	**Viracept**			
Combinations						
Atripla 600/200/300mg **Biktarvy** 50/200/25mg **Combivir** 150/300 mg **Complera** 200/25/300mg **Delstrigo** 100/300/300mg **Dovato** 50/300mg **Epzicom** 600/300mg	**Genvoya** 150/150/200/10mg **Juluca** 50/25mg **Odefsey** 200/25/25mg **Pifeltro** 100mg **Prezcobix** 800/150mg **Stribild** 150/150/200/300mg **Symtuza** 800/150/200/10mg	**Triumeq** 600/50/300mg **Trizivir** 300/150/300mg **Truvada** Prep Adult treatment Pediatric treatment		Take 1 tablet by mouth once daily Take 1 tablet by mouth twice daily Take 1 tablet by mouth daily with a meal ______________________		
Integrase Strand Transfer Inhibitor/CCR5 I						
Isentress 400mg	**Selzentry**	**Tivicay** 50mg	**Vitekta**	Take 1 tablet by mouth twice daily __________________		
gp120 Attachment Inhibitor						
Rukobia ER 600mg				Take 1 tablet by mouth twice daily		
Supportive Medications						
Acyclovir **Bactrim** (TMP/SMX) **Bactrim DS** (TMP/SMX)	**Dapsone** **Diflucan** **Fuzeon**	**Tybost** **Valtrex** **Zithromax**	**Other**			

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ____________________ Signature:____________________ Date: __________

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality 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 named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.