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cienegapharmacy.com

CIENEGA PHARMACY

Infectious Disease Prescription Form

DATE:______________ NEEDS BY DATE:____________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________________________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License#
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ 042 HIV/AIDS ❑ 070.32 Chronic Hepatitis B ❑ 070.54 Chronic Hepatitis C ❑ Other: ______________________

CD/4/T-cell:_____ HIV RNA:_____ HCV genotype:_____ Viral Load:_____ (copies or IU/ml) ALT:_____ Liver Biopsy Results:__________________

Weight: _________ BLOOD RESULTS-Date Drawn: ___________ Hgb/Hct: ___________ WBC: __________

PRESCRIPTION INFORMATION

	DIRECTIONS	QUANTITY	REFILLS
NRTIs/NNRTIs			
❑ Edurant			
❑ Emtriva			
❑ Epivir			
❑ Intelence			
❑ Resciptor			
❑ Retrovir			
❑ Sustiva			
❑ Videx			
❑ Viramune			
❑ Viread			
❑ Zerit			
❑ Ziagen			
Protease Inhibitors			
❑ Aptivus			
❑ Invirase			
❑ Kaletra			
❑ Lexiva			
❑ Norvir			
❑ Prezista			
❑ Reyataz			
❑ Viracept			

	DIRECTIONS	QUANTITY	REFILLS
Combinations			
❑ Atripla			
❑ Combivir			
❑ Complera			
❑ Epzicom			
❑ Stribild			
❑ Trizivir			
❑ Triumeq			
❑ Truvada			
Integrase Inhibitor/CCR5 I			
❑ Isentress			
❑ Selzentry			
❑ Tivicay			
Other Meds			

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

___________________________ Prescriber's Signature (no stamps) ____________ Date ____________ If Brand required check ❑ DAW

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