Padek Healthcare — Quality Care From The Pharmacists You Trust — PHARMACY

Padek Healthcare Hiv Prescription Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name ______ DOB ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Daytime Tel ______ Evening Tel ______ Cell ______ Email ______
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______
ICD-10 Diagnosis ______ Weight ______ Allergies ______ CD4 ______ Viral Load ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______
Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL (NRTI)

COMBIVIR 150/300mg
Tabs | Sol #____ Refill x ______ Sig ______
EMTRIVA 200mg
Caps #____ Refill x ______ Sig ______
EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol #____ Refill x ______ Sig ______
EPZICOM 600/300mg
Tabs #____ Refill x ____Sig ______
RETROVIR 100mg 300mg 10mg/ml
Tabs | Sol #____ Refill x ______ Sig ______
TRIZIVIR 300/150/300mg
Tabs | Sol #____ Refill x ______ Sig ______

TRUVADA 200/300mg
Tabs | Sol #____ Refill x ____Sig ______
VIDEX EC 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd #____ Refill x ____ Sig ______
VIREAD
300mg 250mg 200mg 150mg 40mg/scoop
Pwd #____ Refill x ___ Sig ______
ZERIT
15mg 20mg 30mg 40mg 1mg/ml
Caps | Sol #____ Refill x ____ Sig ______
ZIAGEN 300mg 20mg/ml
Tabs | Sol #____ Refill x ____ Sig ______

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL (NNRTI)

EDURANT 25mg
Tabs #______ Refill x _____ Sig ______
INTELENCE 100 mg 200mg
Tabs #______ Refill x _____ Sig ______

RESCRIPTOR 200mg
Caps #______ Refill x ______ Sig ______
SUSTIVA 50mg 200mg 600mg
Tabs | Caps #_____ Refill x _____ Sig ______
VIRAMUNE 200mg 400mg XR 50mg/5ml
Tabs | Sol #______ Refill x _____ Sig ______

ENTRY INHIBITORS

FUZEON 90mg Refill x_____ Sig ______
SELZENTRY 150mg 300mg Tabs #____ Refill x____ Sig______

PROTEASE INHIBITOR ANTIRETROVIRAL (PI)

APTIVUS 250mg 100mg/ml
Caps #____ Refill x ____ Sig ______
CRIXIVAN 200mg 400mg
Caps #____ Refill x ____ Sig ______
EVOTAZ 300mg 150mg
Tabs #____ Refill x ____ Sig ______
INVIRASE 200mg 500mg
Caps | Sol #____ Refill x ____ Sig ______
KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #____ Refill x ____ Sig ______

LEXIVA 700mg 50mg/ml
Tabs #____ Refill x ____ Sig ______
NORVIR 100mg 80mg/ml
Tabs | Sol #____ Refill x ____ Sig ______
PREZCOBIX 800mg 150mg
Tabs #____ Refill x ____ Sig ______
PREZISTA 75mg 150mg 600mg 800mg
Tabs | Sol #____ Refill x ____ Sig ______
REYATAZ 150mg 200mg 300mg
Caps #____ Refill x ____ Sig ______
VIRACEPT 250mg 625mg
Tabs | Pwd #___ Refill x ____ Sig ______

INTEGRASE INHIBITOR

ISENTRESS 400 mg Tabs #____ Refill x_____ Sig ______
TIVICAY 50mg Tabs #____ Refill x_____ Sig ______

SINGLE TABLET

ATRIPLA Tabs #____ Refill x_____ Sig ______
COMPLERA Tabs #____ Refill x_____ Sig ______
STRIBILD Tabs #____ Refill x_____ Sig ______
TRIUMEQ 600mg/50mg/300mg Tabs #____ Refill x_____ Sig______

OTHER MEDICATION

Other ______ Dose______ Refill x_____ Sig ______
Other ______ Dose______ Refill x_____ Sig ______

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.

PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127