SUPERIOR SPECIALTY PHARMACY
Transforming lives one patient at a time

PATIENT REFERRAL / MEDICATION REQUEST – HIV / AIDS

Phone: 813-960-2020
Fax: 813-549-3810
Toll Free: 877-436-2020

Today Date: ________ Anticipated Start Date: ________ Ship Meds to: ☐ Home ☐ Work ☐ Doctor's Office

Patient Information

Date: ________ Patient SS#: ________ ☐ Male ☐ Female
Patient's First Name: ________ Patient's Last Name: ________
Address: ________ City/County: ________ State: ____ Zip: ____
Home Phone: ________ Alternate Phone: ________ Cell Phone: ________
DOB: ________ Caregiver: ________
Height: ________ Weight: ________ Email: ________
Allergies: ________

Insurance Information

Primary Insurance: ________ Pharmacy Benefit Manager (PBM): ________
Policy #: ________ Group #: ________ Insured: ________ Phone: ________
Medicare: ☐ Yes ☐ No If yes, provide #: ________ Medicaid: ☐ Yes ☐ No If yes, provide #: ________
Secondary Insurance: ________
Policy #: ________ Group #: ________ Insured: ________ Phone: ________

Physician Information

First Name: ________ Last Name: ________ ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Office Address: ________ City: ________ State: ____ Zip: ____
Phone #: ________ Fax #: ________ NPI #: ________
License #: ________ UPIN #: ________ Medical Provider #: ________
Office Contact Name: ________ Email Address: ________ Phone: ________

Diagnosis	Clinic Information
☐ 042 HIV/AIDS ☐ Other: ________	CD4 Count: ________ Viral Load: ________ Date: ________

Prescription Information

(Please select and provide approximate days supply.)
P=preferred PG=preferred generic only (brand medical exception)

	Medication	Strength/Direction	Quantity	Refill
	☐ Atripla			
P	☐ Combivir			
	☐ Epzicom			
	☐ Trizivir			
P	☐ Truvada			
	NRTIs/NNTRIs			
P	☐ Emtriva			
P	☐ Epivir			
	☐ Intelence			
	☐ Rescriptor			
PG	☐ Retrovir (vidovudine)			
P	☐ Sustiva			
PG	☐ Videx EC (didanosine EC)			
P	☐ Viramune			
P	☐ Viread			
PG	☐ Zerit			
P	☐ Ziagen			
	Protease Inhibitors			
	☐ Aptivus			
P	☐ Crixivan			
P	☐ Invirase			
P	☐ Kaletra			
P	☐ Norvir			
	☐ Prezista			
P	☐ Reyetaz			
P	☐ Viracept			
	Integrase Inhibitors			
	☐ Insentress			
	Entry Inhibitors			
	☐ Selzentry			
	Fusion Inhibitors			
	☐ Fuzeon			
	Growth Hormones			
	☐ Serostim			
	Other Meds			
	☐			

Prescriber's Signature (Required by Law): ________ Date: ________

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: ________