ahma (rx)

HIV

Toll free phone: 844.749.6628
Toll free fax: 855.516.3880

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber O˜ice ☐ Alternative Address:			

Prescriber Information

Practice Name:	O˜ice Contact:		
Prescriber :	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Diagnosis: _____ **ICD-10:** _____ **Serum Creatinine:** _____

CD4 Count: _____ **Viral Load:** _____ **Date of labs:** _____

PrEP: _____

Prescription Information

Aptivus®	**Genvoya®**	**Selzentry®**
Atripla®	**Intelence®**	**Stribild®**
Biktarvy®	**Invirase®**	**Sustiva®**
Combivir®	**Isentress®**	**Tivicay®**
Complera®	**Juluca®**	**Triumeq®**
Descovy®	**Kaletra®**	**Trizivir®**
Edurant®	**Lexiva®**	**Truvada®**
Emtriva®	**Norvir®**	**VALCYTE®**
Epivir®	**Odefsey®**	**Viramune®**
Epzicom®	**Prezcobix®**	**Viread®**
Evotaz®	**Prezista®**	**Vitekta®**
Fuzeon®	**Reyataz®**	**Ziagen®**

STRENGTH/DIRECTIONS (SIG):

_____ Qty: _____ Refills: _____

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_____ Qty: _____ Refills: _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty: _____ Refills: _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty: _____ Refills: _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty: _____ Refills: _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty: _____ Refills: _____

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ _____

Date

urac ACCREDITED Specialty Pharmacy