



1. Patient Information

Patient Name: _____ **SSN:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

Sex: Male Female **Height:** _____ **Weight:** lbs. kg. **Known Allergies:** _____

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis: _____ **ICD 10:** _____

4. Prescription Information: For IV medications attach a copy of your prescription

<input type="checkbox"/> Aptivus ® 250mg caps Dispense 1-month supply Take 2 caps 2X daily Refill X _____	<input type="checkbox"/> Atripla ® 600/200/300mg tabs Dispense 30 tabs Take 1 tab QD on empty stomach Refill X _____	<input type="checkbox"/> Combivir ® 150mg/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____	<input type="checkbox"/> Complera 200mg/25mg/300mg tabs Dispense 1-month supply Take 1 tab once daily w/ meal Refill X _____	<input type="checkbox"/> Emtriva ® 200mg caps Dispense 30 capsules Take 1 cap once daily Refill X _____
<input type="checkbox"/> Edurant ® 25mg tabs Dispense 30 tabs Take 1 tab daily with meal Refill X _____	<input type="checkbox"/> Epivir ® <input type="checkbox"/> 300mg tabs <input type="checkbox"/> 600mg tabs Dispense 1-month supply Take _____ caps _____ X daily Refill X _____	<input type="checkbox"/> Epzicom ® 600mg/300mg tabs Dispense 1-month supply Take 1 tab daily Refill X _____	<input type="checkbox"/> Evotaz 300/150mg tabs Dispense 30 tablets Take 1 tab QD with a light meal Refill X _____	<input type="checkbox"/> Fuzeon ® 90mg Inj (1mL) Dispense 1 kit Inject 90mg under skin 2x daily Refill X _____
<input type="checkbox"/> Genvoya ® 150/150/200/10mg tabs Dispense 30 tabs Take 1 tab daily with food Refill X _____	<input type="checkbox"/> Intelence ® 200 mg tabs Dispense 1-month supply Take 1 tab 2X daily following meal Refill X _____	<input type="checkbox"/> Isentress ® 400mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____	<input type="checkbox"/> Kaletra ® <input type="checkbox"/> 200/50mg tabs <input type="checkbox"/> 100/25mg tabs Dispense 120 tabs Take _____ tabs _____ X daily Refill X _____	<input type="checkbox"/> Lexiva ® 700mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____
<input type="checkbox"/> Mepron ® 750mg/5ml <input type="checkbox"/> sachet <input type="checkbox"/> suspension Dispense _____ day supply Take _____ ml _____ X daily Refill X _____	<input type="checkbox"/> Norvir ® 100mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	<input type="checkbox"/> Odefsey ™ 200mg/25mg/25mg tabs Dispense 30 tabs Take 1 tab daily with food Refill X _____	<input type="checkbox"/> Prezcobix 800/150mg tabs Dispense 30 tablets Take 1 tab daily with food Refill X _____	<input type="checkbox"/> Prezista ® _____ mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____
<input type="checkbox"/> Rescriptor ® 200mg caps Dispense 180 capsules Take 2 caps 3X daily Refill X _____	<input type="checkbox"/> Retrovir ® 300 mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	<input type="checkbox"/> Reyataz ® _____ mg caps Dispense 1-month supply Take _____ caps _____ X daily Refill X _____	<input type="checkbox"/> Selzentry ® _____ mg tabs Dispense 1-month supply Take _____ tabs _____ X daily Refill X _____	<input type="checkbox"/> Serostim ® _____ mg Dispense 1-month supply Inject _____ mg SC daily Refill X _____
<input type="checkbox"/> Stribild ™ 150mg/150mg/200mg/300mg tablets Dispense 1-month supply Take 1 tablet daily with food Refill X _____	<input type="checkbox"/> Sustiva ® 600mg tablets Dispense 30 tablets Take 1 tab at bedtime Refill X _____	<input type="checkbox"/> Tivicay 50mg tabs Dispense 1-month supply Take 1 tablet _____ X daily Refill X _____	<input type="checkbox"/> Triumeq ® 600/50/300mg tabs Dispense 30 tablets Take 1 tablet by mouth daily with or without food Refill X _____	<input type="checkbox"/> Trizivir ® 300/150/300mg tabs Dispense 60 tabs Take 1 tab 2X daily Refill X _____
<input type="checkbox"/> Truvada ® 200mg/300mg tabs Dispense 30 tabs Take 1 tab once daily Refill X _____	<input type="checkbox"/> Tybost 150mg tabs Dispense 30 tabs Take 1 tab daily Refill X _____	<input type="checkbox"/> Viramune ® 200mg tabs Dispense _____ tabs Take 1 tab _____ X daily Refill X _____	<input type="checkbox"/> Viread ® 300mg tabs Dispense _____ tablets Take once daily Refill X _____	<input type="checkbox"/> Vitekta _____ mg tabs Dispense 1-month supply Take 1 tab daily Refill X _____
<input type="checkbox"/> Ziagen ® <input type="checkbox"/> 300mg tabs <input type="checkbox"/> 600mg tabs Dispense _____ tabs Take _____ tabs _____ X daily Refill X _____	<input type="checkbox"/> Zerit ® _____ mg caps Dispense 1-month supply Take _____ mg every 12 hours Refill X _____	Other: _____ _____ Refill X _____	Other: _____ _____ Refill X _____	Other: _____ _____ Refill X _____

Ship to: Patient Office Other

5. Physician Information:

Prescriber Name: _____ **Prescriber NPI:** _____ **DEA#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Office Contact: _____ **Fax Number:** _____ **Phone Number:** _____

Office Contact Email: _____

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

Dispense as written

Substitution Permissible

Prescriber's Signature _____ Date _____

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This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.