

patient information

patient: \_\_\_\_\_ female DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
last name, first name male  
 address: \_\_\_\_\_  
street city cell alternate phone number: state zip cell  
 primary phone number: \_\_\_\_\_  
 caregiver: \_\_\_\_\_ allergies: \_\_\_\_\_ NKDA  
 comorbidities: \_\_\_\_\_ height: \_\_\_\_\_ weight: \_\_\_\_\_  
lbs kg date:

clinical information

Diagnosis ICD-10 \_\_\_\_\_ SCr: \_\_\_\_\_ date: \_\_\_\_\_ GFR: \_\_\_\_\_ date: \_\_\_\_\_ HLA-B\*5701 positive or negative  
circle one if applicable  
 New to current therapy? yes no CD4: \_\_\_\_\_ date: \_\_\_\_\_ HIV RNA: \_\_\_\_\_ date: \_\_\_\_\_

prescriptions

medication	dose, route and frequency	qty	refills
<input type="checkbox"/> Atripla (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	Take 600mg/200mg/300mg tablet by mouth once daily	30	
<input type="checkbox"/> Complera (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)	Take 200mg/25mg/300mg tablet by mouth once daily	30	
<input type="checkbox"/> Descovy (emtricitabine/tenofovir alafenamide)	Take 200mg/25mg tablet by mouth once daily	30	
<input type="checkbox"/> Intelence (etravirine)	Take 200 mg tablet by mouth twice daily	60	
<input type="checkbox"/> Isentress (raltegravir)	Take 400 mg tablet by mouth twice daily	60	
<input type="checkbox"/> Isentress HD (raltegravir)	Take two 600mg tablets by mouth once daily	60	
<input type="checkbox"/> Norvir (ritonavir)	Take ___ mg by mouth ___ times a day	___ 100 mg tablets	
<input type="checkbox"/> Prezcobix (darunavir/cobicistat)	Take 800mg/150mg tablet by mouth once daily	30	
<input type="checkbox"/> Prezista (darunavir)	<input type="checkbox"/> Take 800mg tablet by mouth once daily	30	
	<input type="checkbox"/> Take 600mg tablet by mouth twice daily	60	
<input type="checkbox"/> Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)	Take 150mg/150mg/200mg/300mg tablet by mouth once daily	30	
<input type="checkbox"/> Symtuza (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	Take 800mg/150mg/200mg/10mg tablet by mouth once daily	30	
<input type="checkbox"/> Tivicay (dolutegravir)	<input type="checkbox"/> Take 50mg tablet by mouth once daily	30	
	<input type="checkbox"/> Take 50mg tablet by mouth twice daily	60	
<input type="checkbox"/> Triumeq (abacavir/ dolutegravir/lamivudine)	Take 600mg/50mg/300mg tablet by mouth once daily	30	
<input type="checkbox"/> Truvada (emtricitabine/tenofovir disoproxil fumarate)	Take 200mg/300mg tablet by mouth once daily	30	
<input type="checkbox"/> Other medication: _____	_____	___	

prescriber + shipping information

prescriber (print): \_\_\_\_\_ office contact: \_\_\_\_\_  
 preferred method of contact: phone fax email preferred contact persons email: \_\_\_\_\_  
 ship to: patient office alternate \_\_\_\_\_  
shipping address: street city state zip  
 office address: \_\_\_\_\_  
(street, suite, city, state, zip)  
 phone: \_\_\_\_\_ fax: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 prescriber's signature: \_\_\_\_\_ date: \_\_\_\_\_

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

insurance information: please fax copy of insurance card (front + back)