

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name: _____

Address: _____

City, State, ZIP: _____

Primary Phone: - - - - - DOB: / /

Alternate Phone: - - - - - Gender: _____

Email: _____

Primary Language: _____ Last Four of SSN: _____

2. PRESCRIBER INFORMATION

Name: _____

DEA #: _____ NPI #: _____ State Lic. #: _____

Group or Hospital: _____

Address: _____

City, State, Zip: _____

Phone: - - - - - Fax: - - - - -

Contact Person: _____ Phone: - - - - -

3. INSURANCE INFORMATION *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name: _____	Secondary Insurance Company Name: _____
Primary Cardholder Name: _____	Secondary Cardholder Name: _____
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - - - - Member ID: _____ Group #: _____	Phone: - - - - - Member ID: _____ Group #: _____

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: Patient Office Other:

Date of Diagnosis: / /

<input type="radio"/> B20 HIV / AIDS <input type="radio"/> B18.1 Chronic viral hepatitis B w/o delta-agent <input type="radio"/> B18.2 Chronic viral hepatitis C <input type="radio"/> R64 Cachexia (HIV wasting) <input type="radio"/> Other (Specify): _____	LAB DATA			
		Baseline Lab Value	Date	Baseline Lab Value
HIV RNA:		/ /		/ /
CD4/T cell:				
Hgb:		/ /		/ /

Treatment: Naive Experienced

Height (in/cm): _____ Weight (lb/kg): _____ BMI: _____

If applicable, HLA-B*5701: _____ Results: _____ Date: / /

Allergies: _____

Other Medications: _____

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills
<input type="radio"/> Atripla	300/200/600				<input type="radio"/> Procrit				
<input type="radio"/> Combivir	300/150				<input type="radio"/> Reyataz				
<input type="radio"/> Complera	300/200/25				<input type="radio"/> Selzentry				
<input type="radio"/> Descovy					<input type="radio"/> Stribild	150/150/200/300			
<input type="radio"/> Edurant					<input type="radio"/> Sustiva				
<input type="radio"/> Emtriva	200 mg				<input type="radio"/> Tivicay				
<input type="radio"/> Eпивir					<input type="radio"/> Trizivir	300/150/300			
<input type="radio"/> Epzicom™	600/300				<input type="radio"/> Triumeq				
<input type="radio"/> Evotaz					<input type="radio"/> Truvada	300/200			
<input type="radio"/> Genvoya					<input type="radio"/> Tybost				
<input type="radio"/> Intelence	100 mg				<input type="radio"/> Videx EC				
<input type="radio"/> Isentress	400 mg				<input type="radio"/> Viracept				
<input type="radio"/> Kaletra	200/50				<input type="radio"/> Viramune XR				
<input type="radio"/> Lexiva	700 mg				<input type="radio"/> Viread	300 mg			
<input type="radio"/> Norvir	100 mg				<input type="radio"/> Zerit				
<input type="radio"/> Odefsey					<input type="radio"/> Ziagen				
<input type="radio"/> Precobix					<input type="radio"/>				
<input type="radio"/> Prezista					<input type="radio"/>				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X _____ / / X _____ / /

DISPENSE AS WRITTEN _____ DATE _____ PRODUCT SUBSTITUTION PERMITTED _____ DATE _____

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