



SPECIALTY PHARMACY

INFECTIOUS DISEASE

Los Angeles, CA phone 323.935.1186 fax 323.936.0312

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone Alternate Phone	
Social Security #	
Date of Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	

PRESCRIBER INFO		
Prescriber Name		
DEA # NPI # License #		
Address		
City, State, Zip		
Phone Fax		
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: B20 HIV/AIDS B18.1 Chronic Hepatitis B B18.2 Chronic Hepatitis C Other: _____

Drug Allergies: _____

CD/4/T-cell: _____ HIV RNA: _____ HCV genotype: _____ Viral Load: _____ (copies or IU/ml) ALT: _____ Liver Biopsy Results: _____

Weight: _____ BLOOD RESULTS-Date Drawn: _____ Hgb/Hct: _____ WBC: _____

PRESCRIPTION INFORMATION

DIRECTIONS		QUANTITY	REFILLS	DIRECTIONS		QUANTITY	REFILLS
NRTIs/NNRTIs				Combinations			
<input type="checkbox"/> Edurant				<input type="checkbox"/> Atripla			
<input type="checkbox"/> Emtriva				<input type="checkbox"/> Combivir			
<input type="checkbox"/> Efavir				<input type="checkbox"/> Complera			
<input type="checkbox"/> Intence				<input type="checkbox"/> Epzicom			
<input type="checkbox"/> Rescriptor				<input type="checkbox"/> Genvoya			
<input type="checkbox"/> Retrovir				<input type="checkbox"/> Odefsey			
<input type="checkbox"/> Sustiva				<input type="checkbox"/> Stribild			
<input type="checkbox"/> Videx				<input type="checkbox"/> Trizivir			
<input type="checkbox"/> Viramune				<input type="checkbox"/> Truvada			
<input type="checkbox"/> Viread				Integrase Inhibitor/CCR5 In			
<input type="checkbox"/> Zerit				<input type="checkbox"/> Isentress			
<input type="checkbox"/> Ziagen				<input type="checkbox"/> Selzentry			
Protease Inhibitors				<input type="checkbox"/> Tivicay			
<input type="checkbox"/> Aptivus				Other Meds			
<input type="checkbox"/> Invirase				<input type="checkbox"/> Egrifta			
<input type="checkbox"/> Kaletra				<input type="checkbox"/> Serostim			
<input type="checkbox"/> Lexiva							
<input type="checkbox"/> Norvir							
<input type="checkbox"/> Prezista							
<input type="checkbox"/> Reyataz							
<input type="checkbox"/> Viracept							

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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