BERGEN AVE DRUGS
Specialty Pharmacy

HIV PRESCRIPTION REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306
Tel 201.521.0545 | Fax 201.521.0546

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date _____ Anticipated Start Date _____

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name First Name Middle Name Last Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Diagnosis _____ Allergies _____ CD4 _____ Viral Load _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg
Tabs | Sol #_____ Refill x _____ Sig _____

DESCOVY 200/25mg
Tabs #_____ Refill x _____ Sig _____

EMTRIVA 200mg
Caps #_____ Refill x _____ Sig _____

EPIVIR 150mg 300mg 10mg/ml
Tabs | Sol #_____ Refill x _____ Sig _____

EPZICOM 600/300mg
Tabs #_____ Refill x _____Sig _____

RETROVIR 100mg 300mg Oral Sol. 10mg/ml
Tabs | Sol #_____ Refill x _____ Sig _____

TRIZIVIR 300/150/300mg
Tabs | Sol #_____ Refill x _____ Sig _____

TRUVADA 200/300mg
Tabs | Sol #_____ Refill x _____Sig _____

VIDEX EC 125mg 200mg 250mg 400mg
PLAIN VIDEX SOLUTION 10mg/ml
Tabs | Pwd #_____ Refill x _____ Sig _____

VIREAD 300mg
Tabs | Sol #_____ Refill x _____ Sig _____

ZERIT 15mg 20mg 30mg 40mg Oral Sol. 1mg/ml
Caps | Sol #_____ Refill x _____ Sig _____

ZIAGEN 300mg Oral Sol. 20mg/ml
Tabs | Sol #_____ Refill x _____ Sig _____

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml
Caps #_____ Refill x _____ Sig _____

CRIXIVAN 200mg 333mg 400mg
Caps #_____ Refill x _____ Sig _____

EVOTAZ 300mg 150mg
Tabs #_____ Refill x _____ Sig _____

INVIRASE 200mg 500mg
Caps | Sol #_____ Refill x _____ Sig _____

KALETRA
100mg/25mg 200mg/50mg 400mg/100mg/5ml
Tabs | Sol #_____ Refill x _____ Sig _____

LEXIVA 700mg Oral Susp. 50mg/ml
Tabs #_____ Refill x _____ Sig _____

NORVIR 100mg 80mg/ml
Caps | Sol #_____ Refill x _____ Sig _____

PREZCOBIX 800mg 150mg
Tabs #_____ Refill x _____ Sig _____

PREZISTA 75mg 150mg 400mg 600mg
Tabs | Sol #_____ Refill x _____ Sig _____

REYATAZ 100mg 150mg 200mg 300mg
Caps #_____ Refill x _____ Sig _____

VIRACEPT 250mg 625mg
Tabs | Pwd #_____ Refill x _____ Sig _____

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg
Tabs #_____ Refill x _____ Sig _____

INTELENCE 100 mg 200mg
Tabs #_____ Refill x _____ Sig _____

RESCRIPTOR 200mg
Caps #_____ Refill x _____ Sig _____

SUSTIVA 50mg 200mg 600mg
Tabs | Caps #_____ Refill x _____ Sig _____

VIRAMUNE 200mg 50mg/5ml
Tabs | Sol #_____ Refill x _____ Sig _____

FUSION INHIBITORS

FUZEON 90mg Refill x _____ Sig _____

OTHER MEDICATIONS

ATRIPLA Tabs #____ Refill x_____ Sig _____
COMPLERA Tabs #____ Refill x_____ Sig _____
ISENTRESS 400 mg Tabs #____ Refill x_____ Sig _____
ODEFSEY Tabs #____ Refill x_____ Sig _____
STRIBILD Tabs #____ Refill x_____ Sig _____

HGH

SEROSTIM ☐ 4mg ☐ 5mg ☐ 6mg Refill x _____ Sig _____

ADDITIONAL MEDICATION _____ Tabs #_____ Refill x _____ Sig _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

Please fax completed form to **Bergen** at **201.521.0546**

Visit us at **WWW.BERGENDRUGS.COM** for online fillable forms.