BROADWAY SPECIALTY PHARMACY

HIV

Fax: 833.803.3110
Phone: 800.640.8207
broadwayrx.health

1. PATIENT INFORMATION

**** PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK ****

NAME:		ADDRESS:	CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:	SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:	ALLERGIES: NKDA ☐ LATEX ☐		

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: _____ HISTORY: ☐ NEW ☐ RESTART ☐ CONTINUING

LABORATORY TESTS: ENTER DATE AND RESULT BELOW					DIAGNOSIS / ICD-10
☐ CD/4/T-CELL		☐ HIV RNA	☐ VIRAL LOAD	☐ Hgb/Hct	☐ WBC
_____ _____		_____ _____	_____ _____	_____ _____	_____ _____

3. Rx

IF SHIPPING TO PRESCRIBER: NEXT APPT DATE: _____ ☐ FIRST FILL ☐ ALL FILLS

MEDICATION			DOSE & DIRECTIONS	QUANTITY	REFILLS
SINGLE TABLET REGIMENS					
☐ ATRIPLA® (EFV/FTC/TDF) ☐ BIKTARVY® (bictegravir/FTC/TAF) ☐ COMPLERA® (FTC/rilpivirine/TDF) ☐ GENVOYA® (elvitegravir/cobicistat/emtricitabine/TAF)	☐ JULUCA® (dolutegravir/rilpivirine) ☐ ODEFSEY® (rilpivirine/emtricitabine/TAF) ☐ STRIBILD® (EVG/COB/FTC/TDF) ☐ TRIUMEQ® (dolutegravir/abacavir/lamivudine)		☐ TAKE 1 TABLET DAILY ☐ TAKE 1 TABLET TWO TIMES DAILY ☐ TAKE 1 TABLET DAILY WITH FOOD ☐ _____		
NRTIs					
☐ COMBIVIR® (lamivudine/zidovudine) ☐ DESCOVY® (emtricitabine/TAF) ☐ EMTRIVIA® (emtricitabine) ☐ EPIVIR® (lamivudine) ☐ EPZICOM® (abacavir/lamivudine) ☐ RETROVIR® (zidovudine) ☐ TRIZIVIR® (ABC/3TC/AZT)	☐ TRUVADA® (emtricitabine/TDF) ☐ VIDEX EC® (didanosine) ☐ VEMLIDY (TAF) ☐ VIREAD® (TDF) ☐ ZERIT® (stavudine) ☐ ZIAGEN® (avacavir)				
NNRTIs					
☐ EDURANT® (rilpivirine) ☐ INTELENCE® (entravirine) ☐ RESCRIPTOR® (delavirdine)	☐ SUSTIVA® (efavirenz) ☐ VIRAMUNE XR® (nevirapine)				
PROTEASE INHIBITORS					
☐ APTIVUS® (tipranavir) ☐ CRIXIVAN® (indinavir) ☐ EVOTAZ® (atazanavir/cobistat) ☐ INVIRASE® (saquinavir) ☐ KALETRA® (lopinavir/ritonavir) ☐ LEXIVA® (fosamprenavir)	☐ NORVIR® (ritonavir) TABLET ☐ NORVIR® (ritonavir) CAPSULE ☐ PREZCOBIX® (darunavir/cobicistat) ☐ PREZISTA® (darunavir) ☐ REYATAZ® (atazanavir) ☐ VIRACEPT® (nelfinavir)				
INTEGRASE INHIBITORS / CCR5 I					
☐ ISENTRESS® (raltegravir) ☐ TIVICAY® (dolutegravir)	☐ VITEKTA® (elvitegravir) ☐ SELZENTRY® (maraviroc)				
SUPPORTIVE MEDICATIONS					
☐ ACYCLOVIR* ☐ BACTRIM® (400/80mg) ☐ BACTRIM DS® (800/160mg) ☐ DAPSONE	☐ DIFLUCAN® (fluconazole) ☐ FUZEON® (enfuvirtide) ☐ TYBOST® (cobicistat) ☐ VALACYCLOVIR	☐ ZITHROMAX®(azithromycin) ☐ _____ ☐ _____ ☐ _____			

4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL

PRESCRIBER SIGNATURE: I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	

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