Prescription & Enrollment Form
HIV/Antivirals

(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name	First Name
Social Security #	Date of Birth
Parent or Guardian	
Home Phone	Other Contact Phone
Home Address	
City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

☐ 042.9 Acquired Immune Deficiency Syndrome (AIDS), unspecified	Viral Load date
☐ 044.9 Human immunodeficiency virus (HIV) infection	CD4 Count date
☐ Other ICD 9	Ht. Wt.
New to therapy ☐ yes ☐ no If no, date therapy began	Allergies:
Date of diagnosis:	

PREVIOUS MEDICATIONS (Please specify dosage & time on therapy)

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills

SUPPLIES NEEDED (if medication is to be administered in the patient's home):
If checked, please specify the size and type (if applicable):
☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other

Method of Administration:
☐ PIC ☐ Port ☐ IV

Needed:

Physician's Name (Please Print)

Physician's Address

Phone Fax

Dr.'s Office Contact Name

Physician's Signature Date

Physician's DEA#

License # NPI #

Fax completed form to Medex BioCare (866) 755-6339

updated 06/15/09