MAIN POINT OF CONTACT  Name:		ASP CARES	Injection Training: ☐ MD Office ☐ Pharmacy to Arrange  Ship To : ☐ Patient Home ☐ MD Office		
		HIV/AIDS			
		n: (214) 919-2090 or (877) 753-6878			
Phone:		Fax: 1 (888) 294-9434	Ship To: L	■ Patient Home ■	■ MD Office
PATIENT INFORMATION (Use		<u> </u>			
		one:			
Home Address:		City:	_ State:	_Zip Code:	
		Sex: 🗆 Male 🗖 Female Hei	ight:	Weight:	lbs.
Emergency Contact:					
		attach copy of insurance card(s))			
Primary Insurance:		Secondary Insurance	:		
		ID#:			
RxGroup:	Pcn:	RxGroup:	Pc	:n:	
<b>MEDICAL ASSESSMENT (Use</b>	this area or atta	ch patient labs and other authoriz	ation inform	ation)	
Primary Diagnosis:			ICD10	Code:	
PRESCRIPTION INFORMATIO	N *(Use this area	a or attach copy of RX(s))			
☐ Aptivus	☐ Genoya	☐ Rescriptor	I	☐ Truvada	
☐ Atripla	☐ Intelence	□ Retrovir		☐ Tybost	
☐ Combivir	☐ Isentress	☐ Reyataz	]	☐ Viramune	
☐ Complera	☐ Kalertra	☐ Selzentry	[	□ Viread	
☐ Emtriva	☐ Lexiva	☐ Serostim	[	□ Vitekta	
☐ Edurant	☐ Mepron	☐ Stribild		□ Ziagen	
☐ Epivir	☐ Norvir	☐ Sustiva		□ Zerit	
☐ Epzicom	☐ Odefsey	☐ Tivicay	I	☐ Zithromax	
□ Evotaz	☐ Prezcobix	☐ Triumeq			
☐ Fuzeon	☐ Prezista	☐ Trizivir			
RX 1: Drug Name/Strength:_					
Sig:					
Qty:		Refills:			
DV 2. Davis Name /Character					
Sig:		Dofille			
Qty		Refills:			
RX 3: Drug Name/Strength:					
		D. CH.			
Qty:		Refills:			
RX 4: Drug Name/Strength:					
Sig:					
Qty:		Refills:			
RX 5: Drug Name/Strength:					
Sig:					
Sig: Qty:		Refills:			
		NPI#:			
Address:			State:	Zip Code:	
		Fax:			
*Prescriber Signature			Date	e:	

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Please fax completed form to 1 (888) 294-9434