



SPECIALTY PHARMACY

INFECTIOUS DISEASE

Garden Grove, CA toll free 800.228.3643 toll free fax 866.539.1092

krogerspecialtypharmacy.com

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

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	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"/> Epivir				<input type="checkbox"/> Complera			
<input type="checkbox"/> Intelence				<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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