Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

HIV M-Z
Enrollment Form

Physician Offices Call:
855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/________	SS#: _____-_____-_________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: ________	Wt.: ________ Ht.: ________

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/______ ☐**No** **SHIP TO:** ☐ **Patient's Home** ☐**Doctor's Office** ☐ **Other:**___________

Drug	Strength & Quantity	Directions	Refills
☐ **Mytesi®**	125 mg Tablet (Quantity: _____)		
Norvir (ritonavir)	☐80 mg/mL Sol (Quantity: _____) ☐100 mg Pulv (Quantity: _____) ☐100 mg Tablet (Quantity: _____)		
☐ **Odefsey®**	200/25/25 mg Tablet (Quantity: _____)		
☐ **Pifeltro™**	100 mg Tablet (Quantity: _____)		
☐ **Prezcobix®**	800/150 mg Tablet (Quantity: _____)		
Prezista® WEIGHT REQUIRED: _______	☐75 mg Tablet (Quantity: _____) ☐150 mg Tablet (Quantity: _____) ☐600 mg Tablet (Quantity: _____) ☐800 mg Tablet (Quantity: _____) ☐ 100 mg/mL Susp (Quantity: _____)		
Retrovir (zidovudine)	☐10 mg/mL Vial (Quantity: _____) ☐50 mg/5 mL Syr. (Quantity: _____) ☐100 mg Capsule (Quantity: _____) ☐300 mg Tablet (Quantity: _____)		
Reyataz (atazanavir)	☐50 mg Pulv (Quantity: _____) ☐150 mg Capsule (Quantity: _____) ☐200 mg Capsule (Quantity: _____) ☐300 mg Capsule (Quantity: _____)		
☐ **Rukobia**	600 mg Tablet (Quantity: _____)		
Selzentry WEIGHT REQUIRED:_______	☐ 150 mg Tablet (Quantity: _____) ☐ 300 mg Tablet (Quantity: _____)		
☐ **Stribild®**	150/150/200/300 mg Tablet (Quantity: _____)		
Sustiva (efavirenz)	☐50 mg Capsule (Quantity: _____) ☐200 mg Capsule (Quantity: _____) ☐600 mg Tablet (Quantity: _____)		
☐ **Symfi™**	600/300/300 mg Tablet (Quantity: _____)		
☐ **Symfi Lo®**	400/300/300 mg Tablet (Quantity: _____)		
☐ **Symtuza®**	800/150/200/10 mg Tablet (Quantity: _____)		
☐ **Temixys™**	300/300 mg Tablet (Quantity: _____)		
Tivicay	☐10 mg Tablet (Quantity: _____) ☐25 mg Tablet (Quantity: _____) ☐50 mg Tablet (Quantity: _____)		
☐ **Tivicay PD** WEIGHT REQUIRED:______	5mg Tablet (for oral susp) (Quantity: _____)		
☐ **Triumeq**	600/50/300 mg Tablet (Quantity: _____)		
☐ **Trizivir** (abacavir/lamivudine/zidovudine)	300/150/300 mg Tablet (Quantity: _____)		
Truvada (emtricitabine/tenofovir) WEIGHT REQUIRED: _______	☐100/150 mg Tablet (Quantity: _____) ☐133/200 mg Tablet (Quantity: _____) ☐167/250 mg Tablet (Quantity: _____) ☐200/300 mg Tablet (Quantity: _____)		
☐ **Tybost®**	150 mg Tablet (Quantity: _____)		
Viramune (nevirapine)	☐200 mg Tablet (Quantity: _____) ☐50 mg/5 mL Susp. (Quantity: _____)		
Viramune XR (nevirapine)	☐100 mg Tablet (Quantity: _____) ☐400 mg Tablet (Quantity: _____)		
Viracept®	☐250 mg Tablet (Quantity: _____) ☐625 mg Tablet (Quantity: _____)		
Viread® (tenofovir disoproxil fumarate)	☐ 150 mg Tablet (Quantity: _____) ☐ 200 mg Tablet (Quantity: _____) ☐ 250 mg Tablet (Quantity: _____) ☐ 300 mg Tablet (Quantity: _____)		
Ziagen (abacavir)	☐20 mg/mL Solution (Quantity: _____) ☐300 mg Tablet (Quantity: _____)		
Zidovudine	☐50 mg/mL Syrup (Quantity: _____) ☐100 mg Capsule (Quantity: _____) ☐300 mg Tablet (Quantity: _____)		

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ _________________	☐(__________________)	☐	_______________________________

☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Other: ___________________________________

Date of Diagnosis: ____/____/________
Allergies:____

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

To Prescriber: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

PRODUCT SUBSTITUTION PERMITTED	**DISPENSE AS WRITTEN**
X ______________________________ Date: ____/____/________	**X** ______________________________ Date: ____/____/________

CONFIDENTIALITY NOTICE

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