Zarina Pharmacy
SPECIALTY & INFUSION

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HIV

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female	○ Male
Email:		Allergies:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Phone:	Policy #:	Group #:
Secondary Insurance:	Phone:	Policy #:	Group #:

CLINICAL INFORMATION

Diagnosis:	ICD-10:	Serum Creatinine:
CD4 Count:	Viral Load:	Date of Labs:
□ Treatment Naïve □ Treatment Experienced	Prior Treatment Type:	
Comorbidities:		Allergies □ NKDA □ Other_____

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
APRETUDE *(cabotergravir)*	□ 600 mg/vial	Inject 1 dosing kit IM on Month 1 & 2 then every 2 months thereafter	1 dosing kit	
ATRIPLA® *(efavirenz, emtricitabine,tenofovir disoproxil marate)*	□ 600 mg □ 300 mg □ 200 mg	One tablet PO daily on an empty stomach	30 tablets	
BIKTARVY® *(bictegravir, emtricitabine, tenofovir alafenamide)*	□ 50 mg □ 200 mg □ 25 mg	One tablet PO Use daily		
CABENUVA *(amivudine, zidovudine)*	□ 400 mg/ 600 mg/vial □ 300 mg/ 900 mg/vial	Inject 1 dosing kit IM on Month 1 & 2 then every _____ months thereafter	1 dosing kit	
COMBIVIR® *(lamivudine, zidovudine)*	□ 50 mg/ 300 mg	One tablet PO Use 2 times a day (every 12 hours)	60 tablets	
COMPLERA® *(emtricitabine, rilpivirine, tenofovir disoproxil fumarate)*	□ 20 mg/25 mg/ 300 mg	One tablet PO daily with food	1 month supply	
DESUBQOVY® *(emtricitabine, tenofovir alafenamide)*	□ 200 mg/ 25 mg	One capsule PO daily		
DOVATO® *(dolutegravir, lamivudine)*	□ 50 mg/ 300 mg	One tablet PO daily	30 tablets	
EDURANTA® *(rilpivirine)*	□ 25 mg tablet	Take _____ tablet PO daily with food		
EGRIFTA™ *(tesamorelin)*	□ 2 mg vial	Inject 1.4 mg SUBQ once daily	30 days supply	11
EMTRIVA® *(emtricitabine)*	□ 200 mg caps	One capsule PO daily	30 capsules	
EPIVIR® *(lamivudine)*	□ 150 mg caps □ 300 mg caps	One capsule _____ x daily	1 month supply	
EPZICOM® *(abacavir, lamivudine)*	□ 600 mg/ 300 mg tablet	One tablet PO daily	1 month supply	
EVOTAZ™ *(atazanavir, cobicistat)*	□ 300 mg/150 mg tablet	One tablet PO daily with food	30 tablets	
FUZEON® (enfuvirtide)	□ 108 mg/vial	Inject 90 mg SUBQ 2 times a day	1 kit	
GENVOYA® *(elvitegravir, cobicistat, emtricitabine, tenofovir alafenamide)*	□ 150/150/200/10 tablet	One tablet PO daily with food	30 tablets	
INTELENCE® *(etravirine)*	□ 200 mg tablet	One tablet PO 2 times a day	1 month supply	
ISENTRESS® *(raltegravir)*	□ 400 mg tablet	One tablet PO 2 times a day	60 tablets	
KALETRA® *(lopinavir/ritonavir)*	□ 200/ 50 mg tablet	Take _____ tablet _____times a day	120 tablets	
LEXIVA® *(fosamprenavir calcium)*	□ 700 mg tablet	Take _____tablet _____times a day	1 month supply	
NORVIR® *(ritonavir)*	□ 100 mg tablet	Take _____ tablet _____times a day	1 month supply	

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
ODEFSEY® *(emtricitabine, rilpivirine, and tenofovir alafenamide)*	□ 200/25/25 mg tablet	One tablet PO daily with food	30 tablets	
PIFELTRO™ *(doravirine)*	□ 100 mg tablet	One tablet PO daily with food	30 tablets	
PREZCOBIX® *(darunavir and cobicistat)*	□ 800/150 mg tablet	One tablet PO Use daily	30 tablets	
PREZISTA® *(darunavir)*	□ 75 mg tablet □ 150 mg tablet □ 600 mg tablet □ 800 mg tablet □ 100 mg/mL suspension	Take _____ _____times a day	1 month supply	
RUKOBIA® *(fostemsavir)*	□ 60 mg tablet	One tablet PO 2 times a day		
REYATAZ® *(atazanavir sulfate)*	□ 100 mg □ 150 mg □ 200 mg □ 300 mg	Take _____ tablet _____times a day	1 month supply	
SELZENTRY ® *(maraviroc)*	□ _____ mg tablet	Take _____ tablet _____times a day	1 month supply	
STRIBILD® *(elvitegravir, cobicistat, emtricitabletine, tenofovir disoproxil fumarate)*	□ 150/ 150/ 200/ 300 mg tablet	One tablet PO daily with food	1 month supply	
SUSTIVA® *(efavirenz)*	□ 600 mg tablet	Take one tablet at bedtime	30 tablets	
TIVICAY® *(dolutegravir)*	□ 50 mg tablet	Take _____ tablet _____times a day	1 month supply	
TRIUMEQ® *(abacavir, dolutegravir, lamivudine)*	□ 50/600/300 mg tablet	One tablet PO daily with or without food	30 tablets	
TRIZIVIR® *(abacavir, lamivudine, zidovudine)*	□ 300/150/300 mg tablet	One tablet PO 2 times a day	60 tablets	
TROGARZO™ (ibalizumab-uiyk)	□ 150 mg/ mL	□ Induction Dose: 2000 mg IV dose per 250 mL Sodium Chloride 0.9% □ Maintenance Dose: 800 mg IV per 250 mL Sodium Chloride 0.9% every 14 days		
TRUVADA® *(emtricitabletine and tenofovir disoproxil fumarate)*	□ 200/ 300 mg tablet	One tablet PO daily with or without food		
VIRACEPT® *(nelfinavir mesylate)*	□ 250 mg □ 625 mg	Take _____ tablet 3 times a day		
VIRAMUNE XR® *(nevirapine)*	□ 400 mg tablet	One tablet PO daily		
VIREAD® *(tenofovir disoproxil fumarate)*	□ 300 mg tablet	Take _____tablet daily		
ZERIT® *(stavudine)*	□ 15 mg □ 20 mg □ 30 mg □ 40 mg	Take _____ tablet 2 times a day		
□ **OTHER**				
□ **OTHER**				

Start of Therapy Date:

Ship To: ☐ Patient ☐ MD Office

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	
Office Contact:	Email:		
Address:	City:	State:	ZIP:
NPI #:	Tax ID #:		
Prescriber Signature:	Date:		