Touchstone Infusion
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Rowlett, TX 75088
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INFECTIOUS DISEASE: ANTIVIRAL

Date: _____ Needs by Date: _____ Ship to: □ Patient □ Office □ Other _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Contact Person: _____
Phone: _____ Alt Phone: _____	DEA: _____ NPI: _____
Social Security # _____	Address: _____
Date of Birth _____ □ Male □ Female	Phone: _____ Fax: _____

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: _____ Height: _____ □in □cm Weight: _____ □ kg □ lbs

CD/4/T-cell: _____ HIV RNA: _____ HCV genotype: _____ Viral Load: _____ (copies or IU/ml) ALT: _____ Liver Biopsy Result: _____

BLOOD RESULTS- Date Drawn: _____ Hgb/Hct: _____ WBC: _____

PRESCRIPTION INFORMATION

Category	Medication	Directions	Quantity	Refills
NRTIs/NNRTIs	□Edurant			
	□Emtriva			
	□ Epivir			
	□ Intelence			
	□ Rescriptor			
	□ Retrovir			
	□ Sustiva			
	□ Videx			
	□ Viramune			
	□ Viread			
	□ Zerit			
	□ Ziagen			
Protease Inhibitors	□Aptivus			
	□Invirase			
	□ Kaletra			
	□ Lexiva			
	□ Norvir			
	□ Prezista			
	□ Reyataz			
	□ Viracept			
Combinations	□Atripla			
	□Combivir			
	□ Complera			
	□ Epzicom			
	□ Genvoya			
	□ Odefsey			
	□ Stribild			
	□ Trizivir			
	□ Truvada			
Integrase/CCR5 Inhibitors	□Isentress			
	□Selzentry			
	□ Tivicay			
Other Meds	□Egrifta			
	□Serostim			
	□ Acyclovir			
	□			
	□			
	□			

By signing this form and utilizing our services, you are authroizing Touchstone Infusion 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 DAW Date