POLARIS SPECIALTY RX

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
NPI: 1053486795

HIV/AIDs ORDER FORM

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ 340B Eligible: ☐ Yes ☐ No

PATIENT INFORMATION

Last Name: _____
First Name: _____
SSN: _____ Date of Birth: _____
Gender: ☐ M ☐ F Height: _____ Weight: _____ ☐ lbs ☐ kg
Allergies: _____
Best Phone: _____ Alternate Phone: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
☐ MD ☐ DO ☐ NP ☐ PA
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
License #: _____ NPI: _____ DEA#: _____
Phone: _____ Fax: _____
Contact Name: _____ Phone: _____
Collaborating Physician: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS

DIAGNOSIS AND CLINICAL INFORMATION: PLEASE FORWARD A LIST OF CURRENT MEDICATIONS

☐ B20 HIV/AIDS
☐ B18.1 Hepatitis B
☐ B18.2 Hepatitis C
☐ Z20.6 PrEP
☐ Z20.6 PEP
☐ R64 Cachexia (HIV Wasting)
☐ Other: _____

☐ Naïve to treatment ☐ Experienced to treatment

	Lab Values	
Lab	Baseline	Current
CD4/T-Cell Count		
HIV/RNA		

PRESCRIPTION INFORMATION

Medication	Directions	QTY	Refill
Single Tablet Regimens			
☐ ATRIPLA			
☐ BIKTARVY			
☐ COMPLERA			
☐ DELSTRIGO			
☐ DOVATO			
☐ GENVOYA			
☐ JULUCA			
☐ ODEFSEY			
☐ STRIBILD			
☐ SYMFI			
☐ SYMFI LO			
☐ SYMTUZA			
☐ TRIUMEQ			
NRTIs or Nukes			
☐ CIMDUO			
☐ DESCOVY			
☐ EMTRIVA			
☐ EPIVIR			
☐ EPZICOM			
☐ TEMIXYS			
☐ TRUVADA			
☐ VIREAD			
☐ ZIAGEN			
PrEP			
☐ DESCOVY			
☐ TRUVADA			

Medication	Directions	QTY	Refill
PK Enhancer			
☐ TYBOST			
Protease Inhibitors			
☐ EVOTAZ			
☐ KALETRA			
☐ NORVIR			
☐ PREZCOBIX			
☐ PREZISTA			
☐ REYATAZ			
NNRTIs or Non Nukes			
☐ EDURANT			
☐ INTELENCE			
☐ PIFELTRO			
☐ SUSTIVA			
☐ VIRAMUNE			
Entry / Attachment Inhibitor			
☐ SELZENTRY			
☐ TROGARZO			
Integrase Inhibitor			
☐ ISENTRESS			
☐ TIVICAY			
Other			

PRESCRIBER SIGNATURE: PLEASE SIGN AND DATE BELOW

Prescriber Signature – Substitution Permissible | Date | Prescriber Signature – Dispense as Written | Date

I authorize Polaris Specialty Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including submission of any necessary forms to such health plans.