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# Patient Intake Form-HIV/AIDS

3796 Howell Branch Road • Winter Park, FL 32792  
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TODAY'S DATE \_\_\_\_\_ DATE NEEDED \_\_\_\_\_

PATIENT INFORMATION			
First:	Last:	M.I.:	
Date of Birth:	SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:
Shipping Address (if different from home address):			

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)					
Primary:	PCN:	BIN#	Secondary:	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:	RxGrp#:	RxBIN#:	PCN/ID#:	

DIAGNOSIS	CLINICAL INFORMATION
<input type="checkbox"/> 042 HIV/AIDS <input type="checkbox"/> Other _____	CD4 Count: _____ Viral Load _____ Date: _____

**PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)**

Medication	Strength	Directions	Quantity	Refill	Medication	Strength	Directions	Quantity	Refill
<b>Combination Antiretrovirals</b>					<b>Protease Inhibitors</b>				
<input type="checkbox"/> Atripla					<input type="checkbox"/> Aptivus				
<input type="checkbox"/> Combivir					<input type="checkbox"/> Crixivan				
<input type="checkbox"/> Epzicom					<input type="checkbox"/> Invirase				
<input type="checkbox"/> Trizivir					<input type="checkbox"/> Kaletra				
<input type="checkbox"/> Truvada					<input type="checkbox"/> Lexiva				
<input type="checkbox"/> Complera					<input type="checkbox"/> Norvir				
<b>NRTIs/NNRTIs</b>					<input type="checkbox"/> Prezista				
<input type="checkbox"/> Emtriva					<input type="checkbox"/> Reyataz				
<input type="checkbox"/> Efavirenz					<input type="checkbox"/> Viracept				
<input type="checkbox"/> Intelence					<b>Integrase Inhibitors</b>				
<input type="checkbox"/> Raltegravir					<input type="checkbox"/> Isentress				
<input type="checkbox"/> Retrovir (zidovudine)					<b>Entry Inhibitors</b>				
<input type="checkbox"/> Sustiva					<input type="checkbox"/> Seizentry				
<input type="checkbox"/> Videx EC (didanosine EC)					<b>Fusion Inhibitors</b>				
<input type="checkbox"/> Viremune					<input type="checkbox"/> Fuzeon				
<input type="checkbox"/> Viread					<b>Growth Hormones</b>				
<input type="checkbox"/> Zerit (stavudine)					<input type="checkbox"/> Serostim				
<input type="checkbox"/> Ziagen					<b>Other Meds</b>				
<input type="checkbox"/> Edurant					<input type="checkbox"/>				

ADDITIONAL INSTRUCTIONS	
Please Deliver To: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Dr.'s Office <input type="checkbox"/> 1 <sup>st</sup> dose to MD's office, remaining refills to patient's home	
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Office Contact Name (Nurse, MA, Other)	Phone & Ext.
Physician's Signature:	Date: