HIV Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____
email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

HIVRX-18-03

CLINICAL CONSIDERATIONS

Diagnosis:
☐ B20 HIV Disease

Has patient been tested for:
Hepatitis C ☐Yes ☐No
Hepatitis B ☐Yes ☐No
Test Result:_____

New to current therapy: ☐Yes ☐No
CD4 Count:_____ Date: _____/_____/_____
HIV RNA: _____ Date: _____/_____/_____

History of therapies tried/failed (please include dates and reason for discontinuation):

Immunization History
☐ Influenza
Date: _____ /_____ / _____

℞

Medication	Strength	Directions	Quantity	Refills
NRTIs				
☐ **Emtriva**®	☐ 200 mg			
☐ **Epivir**®	☐ 150 mg ☐ 300 mg			
☐ **Retrovir**®	☐ 100 mg ☐ 300 mg			
☐ **Videx EC**®	☐ 200 mg ☐ 250 mg ☐ 400 mg			
☐ **Viread**®	☐ 200 mg ☐ 250 mg ☐ 300 mg			
☐ **Zerit**®	☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg			
☐ **Ziagen**®	☐ 300 mg			
NNRTIs				
☐ **Edurant**®	☐ 25 mg			
☐ **Intelence**®	☐ 25 mg ☐ 100 mg ☐ 200 mg			
☐ **Pifeltro**™	☐ 100 mg			
☐ **Rescriptor**®	☐ 200 mg			
☐ **Sustiva**®	☐ 200 mg ☐ 600 mg			
☐ **Viramune**®	☐ 200 mg			
☐ **Viramune XR**®	☐ 100 mg ☐ 400 mg			
Pharmacokinetic Boosters				
☐ **Tybost**®	☐ 150 mg			
Protease Inhibitors				
☐ **Aptivus**®	☐ 250 mg			
☐ **Crixivan**®	☐ 200 mg ☐ 400 mg			
☐ **Invirase**®	☐ 200 mg ☐ 500 mg			
☐ **Kaletra**®	☐ 200/50 mg ☐ 100/25 mg			
☐ **Lexiva**®	☐ 700 mg			
☐ **Norvir**®	☐ 100 mg			
☐ **Prezista**®	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg			
☐ **Reyataz**®	☐ 150 mg ☐ 200 mg ☐ 300 mg			
☐ **Viracept**®	☐ 250 mg ☐ 625 mg			

Medication	Strength	Directions	Quantity	Refills
Combination Antiretrovirals				
☐ **Atripla**®	☐ 600/200/300 mg			
☐ **Biktarvy®**	☐ 50/200/25 mg			
☐ **Cimduo™**	☐ 300/300 mg			
☐ **Combivir**®	☐ 150/300 mg			
☐ **Complera**®	☐ 200/25/300 mg			
☐ **Descovy**®	☐ 200/25 mg			
☐ **Delstrigo**™	☐ 100/300/300 mg			
☐ **Epzicom**®	☐ 600/300 mg			
☐ **Evotaz**®	☐ 300/150 mg			
☐ **Genvoya**®	☐ 150/150/200/10 mg			
☐ **Juluca**®	☐ 50/25 mg			
☐ **Odefsey**®	☐ 200/25/25 mg			
☐ **Prezcobix**®	☐ 800/150 mg			
☐ **Stribild**®	☐ 150/150/200/300 mg			
☐ **Symfi™**	☐ 60/300/300 mg			
☐ **Symtuza®**	☐ 800/150/200/10 mg			
☐ **Triumeq**®	☐ 600/50/300 mg			
☐ **Trizivir**®	☐ 300/150/300 mg			
☐ **Truvada**®	☐ 200/300 mg ☐ 133/200 mg			
Fusion/Entry Inhibitors				
☐ **Fuzeon**®	☐ 90 mg vial			
☐ **Selzentry**®	☐ 25 mg ☐ 75 mg ☐ 150 mg ☐ 300 mg			
Integrase Inhibitors				
☐ **Isentress**®	☐ 100 mg ☐ 400 mg			
☐ **Isentress HD**®	☐ 600 mg			
☐ **Tivicay**®	☐ 25 mg ☐ 50 mg			
☐ **Vitekta**®	☐ 150 mg			

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____