



Updated August 2020

Patient Name, Today's Date, NEW Patient, CURRENT Patient, DOB, Height, Weight, Male, Female, Preferred Language, Best Phone, Email, Street Address, Apt#, City, State, Zip, Ship to Patient at: Home, Physician Office, Work Address, Allergies, Current Medications including OTC's (please fax a complete list)

Please Fax Insurance Card(s) both sides

Insured's Name, Relation to Patient, Primary Insurance, ID#, Group #, Secondary Insurance, ID#, Group #

Ordering Prescriber

Office Contact, Street Address, Suite #, City, State, Zip, Tel, Fax, Email, License#, NPI#

ICD-10 Code, B20 HIV, B18.2 HCV (chronic), B18.1 HBV (chronic), R64 Cachexia, Other, Diagnosis, Yes (naive), No, Is Patient treatment naive?, If No, what drugs, # of Weeks, CD4/T-Cell Count, HIV RNA Count, Hgb/Hct, ANA, WBC, Creatine Clearance

PRESCRIPTION

NUCLEOSIDE ANALOGS ANTIRETROVIRAL

COMBIVIR 150/300mg, DESCOVY 200/25mg, EMTRIVA 200mg, EPIVIR 150mg 300mg 10mg/ml, EPZICOM 600/300mg, RETROVIR 100mg 300mg Oral Sol. 10mg/ml, TRIZIVIR 300/150/300mg, TRUVADA 200/300mg, VIDEX EC 125mg 200mg 250mg 400mg PLAIN VIDEX SOLUTION 10mg/ml, VIREAD 300mg, ZERIT 15mg 20mg 30mg 40mg Oral Sol. 1mg/ml, ZIAGEN 300mg Oral Sol. 20mg/ml

PROTEASE INHIBITOR ANTIRETROVIRAL

APTIVUS 250mg Oral Susp. 100mg/ml, CRIVAN 200mg 333mg 400mg, EVOTAZ 300mg 150mg, INVIRASE 200mg 500mg, KALETRA 100mg/25mg 200mg/50mg 400mg/100mg/5ml, LEXIVA 700mg Oral Susp. 50mg/ml, NORVIR 100mg 80mg/ml, PREZCOBIX 800mg 150mg, PREZISTA 75mg 150mg 400mg 600mg, REYATAZ 100mg 150mg 200mg 300mg, VIRACEPT 250mg 625mg

HGH SEROSTIM 4mg, 5mg, 6mg, Refill, Sig

OTHER MEDICATIONS

ATRIPLA, BIKTARVY, CIMDUO, COMPLERA, DOVATO, DELSTRIGO 100/300/300 mg (adult dose), ISENTRESS 400 mg, ODEFSEY, RUKOBIA 600mg XR tablet, STRIBILD, SYMTUZA 800/150/200/10mg

FUSION INHIBITORS

FUZEON 90mg, SELZENTRY 150/300

OTHER MEDICATION

Other medication fields

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

NON-NUCLEOSIDE ANALOGS ANTIRETROVIRAL

EDURANT 25mg, PIFELTRO 100 mg tablet (adult dose), INTELENCE 100 mg 200mg, RESCRIPTOR 200mg, SUSTIVA 50mg 200mg 600mg, VIRAMUNE 200mg 50mg/5ml

Prescriber's Signature (signature required. NO STAMPS), Date

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.