



HIV Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Patient Name _____
 Address _____
 City, State, Zip _____
 Preferred phone number _____ Alternate Phone _____
 DOB _____ Gender _____
 Language Preference: English Spanish Other _____
 Allergies/Comments _____
 Concomitant Medications _____
 Weight _____ kg/lbs Height _____ cm/in

PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____
 NPI _____
 Group/Hospital _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: _____

DIAGNOSTIC/CLINICAL INFORMATION | Please fax recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____
 CD4 Count: _____ Viral Load: _____ Date of Labs: _____
 PrEP: Yes No Hep B test completed? Yes No Naïve to Treatment Therapy
 Hep C test completed? Yes No Experienced to Treatment Therapy
 HLA-B*5701 test completed? Yes No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills
<input type="checkbox"/> Biktarvy	<input type="checkbox"/> 50/200/25 mg tablet				<input type="checkbox"/> Odefsey	<input type="checkbox"/> 200/25/25 mg tablet			
<input type="checkbox"/> Cimduo	<input type="checkbox"/> 300/300 mg tablet				<input type="checkbox"/> Prezcobix	<input type="checkbox"/> 800/150 mg tablet			
<input type="checkbox"/> Descovy	<input type="checkbox"/> 200/25 mg tablet				<input type="checkbox"/> Prezista	<input type="checkbox"/> 75 mg tablet <input type="checkbox"/> 150 mg tablet <input type="checkbox"/> 600 mg tablet <input type="checkbox"/> 800 mg tablet <input type="checkbox"/> 100 mg/mL suspension			
<input type="checkbox"/> Dovato	<input type="checkbox"/> 50/300 mg tablet				<input type="checkbox"/> Reyataz	<input type="checkbox"/> 150 mg capsule <input type="checkbox"/> 200 mg capsule <input type="checkbox"/> 300 mg capsule <input type="checkbox"/> 50 mg oral powder			
<input type="checkbox"/> Epzicom	<input type="checkbox"/> 600/300 mg tablet				<input type="checkbox"/> Symtuza	<input type="checkbox"/> 800/150/200/10 mg tablet			
<input type="checkbox"/> Genvoya	<input type="checkbox"/> 150/150/200/10 mg tablet				<input type="checkbox"/> Tivicay	<input type="checkbox"/> 10 mg tablet <input type="checkbox"/> 25 mg tablet <input type="checkbox"/> 50 mg tablet			
<input type="checkbox"/> Intelence	<input type="checkbox"/> 25 mg tablet <input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 200 mg tablet				<input type="checkbox"/> Triumeq	<input type="checkbox"/> 600/50/300 mg tablet			
<input type="checkbox"/> Isentress	<input type="checkbox"/> 25 mg chewable tablet <input type="checkbox"/> 100 mg chewable tablet <input type="checkbox"/> 100 mg granules for suspension <input type="checkbox"/> 400 mg tablet				<input type="checkbox"/> Truvada	<input type="checkbox"/> 100/150 mg tablet <input type="checkbox"/> 133/200 mg tablet <input type="checkbox"/> 167/250 mg tablet <input type="checkbox"/> 200/300 mg tablet			
<input type="checkbox"/> Isentress HD	<input type="checkbox"/> 600 mg tablet				<input type="checkbox"/>				
<input type="checkbox"/> Juluca	<input type="checkbox"/> 50/25 mg tablet				<input type="checkbox"/>				
<input type="checkbox"/> Norvir	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 100 mg powder <input type="checkbox"/> 80 mg/mL solution				<input type="checkbox"/>				

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

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted Dispense as Written
 Prescriber's Signature _____ Date: _____ Supervising Physician Signature: _____ Date: _____
 Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.