HIV / AIDS Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: ☐ Male ☐ Female

Email : _____

Last 4 digits SS#: _____

PRESCRIBER INFORMATION

Name: _____

State License #: _____ NPI #: _____

DEA #: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

Diagnosis: Primary ICD-10 _____ Other ICD-10 _____

Medication	Strength	Directions	Quantity	Refills
COMBINATION ANTIRETROVIRALS				
☐ ATRIPLA	300/200/600mg			
☐ COMBIVIR	300/150mg			
☐ COMPLERA	300/200/50mg			
☐ EPZICOM	600/300mg			
☐ STRIBILD	150/150/200/300mg			
☐ TRIZIVIR	300/150/300mg			
☐ TRUVADA	300/200mg			
☐ TRIUMEQ	50/600/300mg			
☐ GENVOYA	150/150/200/10mg			
☐ ODEFSEY	200/25/200mg			
☐ DESCOVY	200/25mg			
NNRTIs				
☐ EDURANT	25mg			
☐ INETELENCE				
☐ RESCRIPTOR				
☐ SUSTIVA				
☐ VIRAMUNE				
☐ VIRAMUNE XR	400mg			

Medication	Strength	Directions	Quantity	Refills
PROTEASE INHIBITORS				
☐ APTIVUS				
☐ CRIXIVAN				
☐ INVIRASE				
☐ KALETRA				
☐ LEXIVA				
☐ NORVIR Tabs	100mg			
☐ NORVIR Caps	100mg			
☐ PREZISTA				
☐ REYATAZ				
☐ VIRACEPT				
INTEGRASE INHIBITORS				
☐ ISENTRESS				
☐ TIVICAY				
ENTRY/FUSION INHIBITORS				
☐ FUZEON	90mg Vial			
☐ SELZENTRY				
NRTIs				
☐ EMTRIVA				
☐ EPIVIR				
☐ RETROVIR				
☐ VIDEX				
☐ VIREAD				
☐ ZERIT				
☐ ZIAGEN				

Today's Date_____ Date Needed:_____

Ship to: ❑ Patient ❑ Physician Other:_____

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: Date: