

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	Medication	Strength	Directions	Quantity	Refills
COMBINATION ANTIRETROVIRALS					PROTEASE INHIBITORS				
<input type="checkbox"/> ATRIPLA	300/200/600mg				<input type="checkbox"/> APTIVUS				
<input type="checkbox"/> COMBIVIR	300/150mg				<input type="checkbox"/> CRIXIVAN				
<input type="checkbox"/> COMPLERA	300/200/50mg				<input type="checkbox"/> INVIRASE				
<input type="checkbox"/> EPZICOM	600/300mg				<input type="checkbox"/> KALETRA				
<input type="checkbox"/> STRIBILD	150/150/200/300mg				<input type="checkbox"/> LEXIVA				
<input type="checkbox"/> TRIZIVIR	300/150/300mg				<input type="checkbox"/> NORVIR Tabs	100mg			
<input type="checkbox"/> TRUVADA	300/200mg				<input type="checkbox"/> NORVIR Caps	100mg			
<input type="checkbox"/> TRIUMEQ	50/600/300mg				<input type="checkbox"/> PREZISTA				
<input type="checkbox"/> GENVOYA	150/150/200/10mg				<input type="checkbox"/> REYATAZ				
<input type="checkbox"/> ODEFSEY	200/25/200mg				<input type="checkbox"/> VIRACEPT				
<input type="checkbox"/> DESCOVY	200/25mg				INTEGRASE INHIBITORS				
					<input type="checkbox"/> ISENTRESS				
					<input type="checkbox"/> TIVICAY				
					ENTRY/FUSION INHIBITORS				
					<input type="checkbox"/> FUZEON	90mg Vial			
					<input type="checkbox"/> SELZENTRY				
NNRTIs					NRTIs				
<input type="checkbox"/> EDURANT	25mg				<input type="checkbox"/> EMTRIVA				
<input type="checkbox"/> INELENCE					<input type="checkbox"/> EPIVIR				
<input type="checkbox"/> RESCRIPTOR					<input type="checkbox"/> RETROVIR				
<input type="checkbox"/> SUSTIVA					<input type="checkbox"/> VIDEX				
<input type="checkbox"/> VIRAMUNE					<input type="checkbox"/> VIREAD				
<input type="checkbox"/> VIRAMUNE XR	400mg				<input type="checkbox"/> ZERIT				
					<input type="checkbox"/> 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: _____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.