HIV Enrollment Form

Date:______________

Patient Data

Patient Name: ______________________________ Birthdate:______________ Sex: ❑ Male ❑ Female Height: ______ Weight: _______ lbs kg

SSN #: XXX-XX-______________________________ Known Allergies: ______________________________

Address: ______________________________ City: ____________________ State:______________ Zip:______________

Home Phone: ____________________ Cell Phone:____________________ Primary Language:______________________________

Alternate Caregiver Name:______________________________ Phone of Caregiver:______________________________

Ins. Data

Primary Insurance:______________________________ Secondary Insurance: ______________________________

Policy: ______________________________ Group#:____________ Policy: ______________________________ Group#:____________

Clinical Info

Please include hard copies of viral load and pertinent office visit notes to expedite prior authorization process.

Diagnosis: ❑ B20 HIV ❑ Other______________________________ ICD 10 code:______________________________

HIV RNA: ______________________________ Date: ______________________________

Prescription

Medication

❑ **Atripla® (EFV/FTC/TDF) 600/200/300 mg**
One tablet by mouth QD on an empty stomach

❑ **Biktarvy® (BIC/FTC/TAF) 50/200/25 mg**
One tablet by mouth once daily

❑ **Combivir® (lamivudine/zidovudine) 150/300 mg**
One tablet by mouth twice daily

❑ **Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg**
One tablet by mouth once daily with food

❑ **Crixivan® (indinavir) 400 mg**
Two capsules (800 mg) by mouth every 8 hours on an empty stomach

❑ **Descovy® (FTC/TAF) 200/25 mg**
One tablet by mouth once daily

❑ **Edurant™ (rilpivirine) 25 mg**
One tablet by mouth once daily with food

❑ **Emtriva® (emtricitabine) 200 mg**
One capsule by mouth once daily

❑ **Epivir® (lamivudine) 150 mg**
❑ One tablet by mouth twice daily
❑ Two tablets (300 mg) by mouth once daily

❑ **Epzicom® (abacavir/lamivudine) 600/300 mg**
One tablet by mouth once daily

❑ **Evotaz® (atazanavir/cobicistat) 300/150 mg**
One tablet by mouth once daily with food

❑ **Fuzeon® (enfuvirtide) 90 mg**
Inject 90 mg (1 mL) SQ twice daily

❑ **Genvoya® (elvitegravir, cobicistat, FTC, TAF) 150/150/200/10 mg**
One tablet by mouth once daily with food

❑ **Intelence® (etravirine) 100 mg**
Two tablets by mouth twice daily following a meal

❑ **Intelence® (etravirine) 200 mg**
One tablet by mouth twice daily following a meal

❑ **Invirase® (saquinavir) 500 mg**
Two tablets by mouth twice daily (in combination with Ritonavir)

❑ **Isentress® (raltegravir) 400 mg**
One tablet by mouth twice daily

❑ **Isentress® HD (raltegravir) 600 mg**
Two tablets by mouth once daily

❑ **Norvir® (ritonavir) 100 mg tablets**
Take ______ tablet by mouth ______ daily

❑ **Odefsey® (FTC/RPV/TAF) 200/25/25 mg**
One tablet by mouth once daily with a meal

❑ **Prezista® (darunavir) 400 mg**
Two tablets by mouth once daily with food

❑ **Prezista® (darunavir) 600 mg**
One tablet by mouth twice daily with food

❑ **Prezista® (darunavir) 800 mg**
One tablet by mouth once daily with food

❑ **Retrovir® (zidovudine) 300 mg**
One tablet by mouth twice daily

❑ **Reyataz® (atazanavir) 300 mg**
One capsule by mouth once daily with food

❑ **Stribild™ (EVG/COBI/FTC/TDF)**
150/150/200/300 mg
One tablet by mouth once daily with food

❑ **Sustiva® (efavirenz) 600 mg**
One tablet by mouth once daily on an empty stomach

❑ **Tivicay® (dolutegravir) 50 mg**
❑ One tablet by mouth once daily
❑ One tablet by mouth twice daily

❑ **Triumeq® (abacavir, dolutegravir, lamivudine) 600/50/300 mg**
One tablet by mouth once daily

❑ **Trizivir® (abacavir/lamivudine/zidovudine) 300/150/300 mg**
One tablet by mouth twice daily

❑ **Truvada® (FTC/TDF) 200/300 mg**
One tablet by mouth once daily

❑ **Viracept® (nelfinavir) 250 mg**
❑ 5 tablets (1250 mg) by mouth twice daily with food
❑ 3 tablets (750 mg) by mouth three times daily with food

❑ **Viracept® (nelfinavir) 625 mg**
2 tablets (1250 mg) by mouth twice daily with food

❑ **Viread® (TDF) 150 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 200 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 250 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 300 mg**
One tablet by mouth once daily

❑ **Ziagen® (abacavir) 300 mg**
❑ One tablet by mouth twice daily
❑ Two tablets (600 mg) by mouth once daily

❑ **Other** ______________________________
____

❑ **All prescriptions will be dispensed quantity sufficient for 30 days. Refills____________**

Is patient new to this therapy: ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other | **Need by Date:**____________

Prescriber Data

Prescriber Name:______________________________ DEA#:____________________ NPI: ______________

Practice Name: ______________________________ Contact: ______________________________

Address: ______________________________ Phone:____________________ Fax:______________

City: ______________ State:____________ Zip: ____________ Key Contact#:______________________________

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: ______________________________ Date: ______________

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.