HIV CARE PROGRAM

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: __________

Phone: (________) ________ - ______________

Email: ______________________________

DOB: _______ / _______ / _______ Caregiver: ____________________

Height: _________ Weight: _________ Allergies: ____________________

PRESCRIBER INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: __________

Phone: (________) ________ - ______________

Fax: (________) ________ - ______________

NPI: ____________________ DEA: ____________________

STATEMENT OF MEDICAL NECESSITY

Diagnosis/ICD-10 Code: ❑ B20 HIV/AIDS ❑ B97.35 HIV2 ❑ B18.1 HBV (Chronic) ❑ B18.2 HCV (Chronic)

New to current therapy? ❑ Yes ❑ No CD4: ____________________ Date: ______ / ______ / ______ HIV RNA: ____________________ Date: ______ / ______ / ______

PRESCRIPTION INFORMATION

MEDICATION	QTY	REFILLS	MEDICATION	QTY	REFILLS
❑ APTIVUS® (TIPRANAVIR) 250 MG TWO CAPSULES BY MOUTH BID (Q12 HOURS)			❑ RETROVIR® (ZIDOVUDINE)		
			❑ REYATAZ® (ATAZANAVIR)		
❑ ATRIPLA® (EFV/FTC/TDF) 600/200/300 MG ONE TABLET BY MOUTH QD ON AN EMPY STOMACH			❑ SELZENTRY® (MARAVIROC)		
❑ COMBIVIR® (LAMIVUDINE/ZIDOVUDINE) 150/300 MG ONE TABLET BY MOUTH BID (Q12 HOURS)			❑ STRIBID™ (EVG/COBI/FTC/TDF) 150/150/200/300 MG ONE TABLET BY MOUTH QD WITH FOOD		
❑ COMPLERA™ (FTC/RILPIVIRINE/TDF) 200/25/300 MG ONE TABLET BY MOUTH QD WITH FOOD			❑ SUSTIVA® (EFAVIRENZ)		
❑ CRIXIVAN® (INDINAVIR) ONE TABLET BY MOUTH QD WITH A MEAL			❑ TRIZIVIR® (ABC/3TC/AZT) 300/150/300 MG ONE TABLET BY MOUTH BID (Q12 HOURS)		
❑ EDURANT™ (RILPIVIRINE) 25 MG ONE CAPSULE BY MOUTH QD			❑ TRUVADA® (EMTRICITABINE/TENOFOVIR) 200/300 MG ONE TABLET BY MOUTH QD		
❑ EMTRIVIA® (EMTRICITABINE) 200 MG			❑ VIDEX® EC (DIDANOSINE)		
❑ EPIVIR® (LAMIVUDINE)			❑ VIRACEPT® (NELFINAVIR)		
❑ EPZICOM® (ABACAVIR/LAMIVUDINE) 600/300 MG ONE TABLET BY MOUTH QD			❑ VIRAMUNE® (NEVIRAPINE) 200 MG		
			❑ VIRAMUNE® XR™ (NEVIRAPINE ER) 400 MG ONE TABLET BY MOUTH QD		
❑ FUZEON® (ENFUVIRITIDE) 90 MG 90 MG (1 ML) SUB-Q BID (Q12 HOURS)			❑ VIREAD® (TENOFOVIR) 300 MG		
			❑ ZERIT® (STAVUDINE)		
❑ FUZEON® (ENFUVIRITIDE) 90 MG 90 MG (1 ML) SUB-Q BID (Q12 HOURS)			❑ ZIAGEN® (AVACAVIR) 300 MG		
			OTHER MEDICATIONS		
❑ INTELENCE® (ENTRAVIRINE)			❑ ACYLOVIR		
❑ INVIRASE® (SAQUINAVIR)			❑ BACTRIM® (TMC/SMZ)		
❑ ISENTRESS® (RALTEGRAVIR) 400 MG ONE TABLET BY MOUTH BID (Q12 HOURS)			❑ BACTRIM® DS(TMP/SMZ)		
			❑ DAPSONE		
❑ KALETRA® (LOPINAVIR/RITONAVIR) 200/50 MG			❑ DIFLUCAN® (FLUCONAZOLE)		
❑ LAXIVA® (FOSAMPRENAVIR) 200/50 MG			❑ SEROSTIM® (SOMATROPIN)		
❑ NORVIR® (RITONAVIR) CAPSULES 100 MG			❑ VALTREX® (VALACYCLOVIR)		
❑ NORVIR® (RITONAVIR) TABLETS 100 MG			❑ ZITHROMAX® (AZITHROMYCIN)		
❑ PREZISTA® (DARUNAVIR)					
❑ RESCRIPTOR® (DELAVIRDINE)					

INJECTION TRAINING ❑ Pharmacist to Provide Training ❑ Patient Trained in MD Office ❑ Manufacturer Nurse Support

PRODUCT DELIVERY ❑ Patient's Home ❑ Physician's Office ❑ Pharmacy to Coordinate

INSURANCE INFORMATION Please Include Front and Back Copies of Pharmacy and Medical Card

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

SIGNATURE: ____ DATE: _________ / _________ / ___________

PRIOR AUTHORIZATION APPROVAL AND INSURANCE BENEFITS WILL BE DETERMINED BY THE PAYOR BASED UPON THE PATIENT'S ELIGIBILITY, MEDICAL NECESSITY, AND THE TERMS OF THE PATIENT'S COVERAGE, AMONG OTHER THINGS. PARTICIPATION IN THIS PROGRAM IS NOT A GUARANTEE OF PRIOR AUTHORIZATION OR OF PAYMENT. ***CONFIDENTIALITY NOTICE:*** *THIS FAX IS INTENDED TO BE DELIVERED ONLY TO THE NAMED ADDRESSEE AND CONTAINS CONFIDENTIAL INFORMATION THAT MAY BE PROTECTED HEALTH INFORMATION UNDER FEDERAL AND STATE LAWS. IF YOU ARE NOT THE NAMED ADDRESSEE, YOU SHOULD NOT DISSEMINATE, DISTRIBUTE OR COPY THIS FAX. PLEASE INFORM THE SENDER IMMEDIATELY IF YOU HAVE RECEIVED THIS DOCUMENT IN ERROR AND THEN DESTROY THIS DOCUMENT IMMEDIATELY.*