



HIV ENROLLMENT FORM

Fax to: 512-490-6515

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

DATE: _____ **SHIP TO:**
DATE NEEDED: _____ PATIENT OFFICE

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

Emergency Contact: _____ Emergency Contact Phone (____) - ____ - _____

Preferred Method of Contact Phone Email Height: _____ Weight _____ lbs. Allergies: _____

Current Medications: (attach additional pages if necessary) _____ Date _____

PRESCRIPTION BENEFITS INFORMATION (Please Attach front and back of insurance card)

Plan Name: _____ ID # _____ Group#: _____ RxBIN: _____ RxPCN: _____

Date of Diagnosis _____ CD4 Count _____ Date of Lab _____

Diagnosis (ICD-10 Code):
 B20 HIV Disease
 Z20.6 Contact with and (suspected) exposure to HIV
 Other: _____

HIV RNA _____ Date of Lab _____

Has patient been tested for:
 Hepatitis C? Y N If Yes, Positive Negative
 Hepatitis B? Y N If Yes, Positive Negative

New to Treatment? Y N **If No Prior HIV Treatment:**
Dates: _____ Drug Name _____
Reason for Discontinuation _____
Dates: _____ Drug Name _____
Reason for Discontinuation _____

MEDICATION		DOSE/STRENGTH	DIRECTIONS/SIG*	QTY	REFILLS	MEDICATION		DOSE/STRENGTH	DIRECTIONS/SIG*	QTY	REFILLS
COMBINATION ANTIRETROVIRALS						NRTIs					
<input type="checkbox"/> Biktarvy®	<input type="checkbox"/> 50/200/25 mg <input type="checkbox"/> 30/120/15 mg		Take 1 tablet QD			<input type="checkbox"/> Emtriva® (Emtricitabine)	200mg		Take 1 capsule QD		
<input type="checkbox"/> Cimduo®	300/300 mg		Take 1 tablet QD			<input type="checkbox"/> Emtriva® Oral solution	<input type="checkbox"/> 10mg/mL		Give _____ mg or _____ mL QD		
<input type="checkbox"/> Cabenuva Injectable Suspension	<input type="checkbox"/> 600/900 mg <input type="checkbox"/> 400/600 mg		<input type="checkbox"/> _____			<input type="checkbox"/> Epivir® (Lamivudine)	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg				
<input type="checkbox"/> Combivir® (Lamivudine/Zidovudine)	150/300 mg		Take 1 tablet BID			<input type="checkbox"/> Epivir® Oral Solution (Lamivudine)	<input type="checkbox"/> 10mg/mL		Give _____ mg or _____ mL QD		
<input type="checkbox"/> Complera™	200/25/300 mg		Take 1 tablet QD with food			<input type="checkbox"/> Retrovir® (Zidovudine)	10 mg/mL		Give _____ mg or _____ mL BID		
<input type="checkbox"/> Descovy®	<input type="checkbox"/> 200/25 mg <input type="checkbox"/> 120/15 mg		Take 1 tablet QD			<input type="checkbox"/> Viread® (Tenofovir Disoproxil Fumarate)	<input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 250mg <input type="checkbox"/> 300mg		Take _____ mg QD		
<input type="checkbox"/> Delstrigo™	100/300/300 mg		Take 1 tablet QD			<input type="checkbox"/> Ziagen® (Abacavir)	<input type="checkbox"/> 300mg				
<input type="checkbox"/> Dovato	50/300 mg		Take 1 tablet QD			<input type="checkbox"/> Zidovudine	<input type="checkbox"/> 100mg <input type="checkbox"/> 300mg		<input type="checkbox"/> Take 1 tablet QD <input type="checkbox"/> Take _____ capsule QD		
<input type="checkbox"/> Efavirenz/ Emtricitabine/Tenofovir	600/200/300mg		Take 1 tablet QD on an empty stomach			NNRTIs					
<input type="checkbox"/> Epiqom® (Abacavir/ Lamivudine)	600/300 mg		Take 1 tablet QD			<input type="checkbox"/> Edurant®	<input type="checkbox"/> 25mg		Take 1 tablet QD with food		
<input type="checkbox"/> Evotaz™	300/150 mg		Take 1 tablet QD with food			<input type="checkbox"/> Intelence® (Etravirine)	<input type="checkbox"/> 25mg <input type="checkbox"/> 100mg		Take _____ tablet(s) BID		
<input type="checkbox"/> Genvoia®	150/150/200/10 mg		Take 1 tablet QD with food			<input type="checkbox"/> Pifeltro™	100mg		Take 1 tablet QD with or without food		
<input type="checkbox"/> Juluca	50/25 mg		Take 1 tablet QD with food			<input type="checkbox"/> Sustiva® (Efavirenz)	<input type="checkbox"/> 50mg <input type="checkbox"/> 200mg <input type="checkbox"/> 600mg				
<input type="checkbox"/> Odefsey®	200/25/25 mg		Take 1 tablet QD with food			<input type="checkbox"/> Nevirapine	<input type="checkbox"/> 200mg <input type="checkbox"/> ER400mg <input type="checkbox"/> 50mg/5mL				
<input type="checkbox"/> Prezcoibix™	800/150 mg		Take 1 tablet QD with food			Pharmacokinetic Boosters					
<input type="checkbox"/> Stribild®	150/150/200/300 mg		Take 1 tablet QD with food			<input type="checkbox"/> Tybost®	150mg		Take 1 tablet QD		
<input type="checkbox"/> Symfi®	600/300/300 mg		Take 1 tablet HS on an empty stomach			PROTEASE INHIBITORS					
<input type="checkbox"/> Symfi Lo™	400/300/300 mg		Take 1 tablet HS on an empty stomach			<input type="checkbox"/> Aptivus®	250mg		Take 2 tablets BID		
<input type="checkbox"/> Tenofovir	600/200/300mg		Take 1 tablet QD on an empty stomach			<input type="checkbox"/> Kaletra® (Lopinavir – Ritonavir)	<input type="checkbox"/> 100mg/25mg <input type="checkbox"/> 200mg/50mg <input type="checkbox"/> 80-20mg/ML				
<input type="checkbox"/> Triumeq®	600/50/300 mg		Take 1 tablet QD			<input type="checkbox"/> Lexiva® (Fosamprenavir Calcium)	700 mg				
<input type="checkbox"/> Triumeq PD	60/50/30 mg		Disperse _____ tablets for oral suspension in 20ml of drinking water and give QD			<input type="checkbox"/> Norvir® (Ritonavir)	<input type="checkbox"/> 100mg Tablet <input type="checkbox"/> 100mg Powder				
<input type="checkbox"/> Trizivir	300/150/300 mg		Take 1 tablet BID			<input type="checkbox"/> Prezista®	<input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 600mg <input type="checkbox"/> 800mg <input type="checkbox"/> 100mg/mL				
<input type="checkbox"/> Truvada®	<input type="checkbox"/> 100/150 mg <input type="checkbox"/> 133/200 mg <input type="checkbox"/> 167/250 mg <input type="checkbox"/> 200/300 mg		<input type="checkbox"/> Take 1 tablet QD <input type="checkbox"/> Take 2 tablets 2 – 24 hours before intercourse, followed by 1 tablet 24 hours after the initial two-tablet dose, followed by 1 tablet 48 hours after the initial two-tablet dose			<input type="checkbox"/> Reyataz® (Atazanavir)	<input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg				
INTEGRASE INHIBITORS						FUSION/ENTRY INHIBITORS					
<input type="checkbox"/> Isentress® Chewable	<input type="checkbox"/> 25mg <input type="checkbox"/> 100mg		Chew _____ tablets BID			<input type="checkbox"/> Fuzeon®	90mg vial				
<input type="checkbox"/> Isentress®	400mg		Take 1 tablet BID			<input type="checkbox"/> Selzentry® (Maraviroc)	<input type="checkbox"/> 150mg <input type="checkbox"/> 300mg <input type="checkbox"/> 20mg/mL				
<input type="checkbox"/> Isentress® HD	600mg		Take 2 tablets QD			OTHER					
<input type="checkbox"/> Tivicay®	<input type="checkbox"/> 10mg <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg		<input type="checkbox"/> Take 1 tablet QD <input type="checkbox"/> Take 1 tablet BID								
<input type="checkbox"/> Tivicay PD®	<input type="checkbox"/> 5mg		<input type="checkbox"/> Take _____ tablets QD <input type="checkbox"/> Disperse _____ tablets for oral suspension in _____ mL of drinking water and give QD								

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____

Telephone: _____ Fax: _____ Email: _____

Office Address: _____ City: _____ State: _____ Zip: _____

NPI # : _____ License # : _____ TAX ID # : _____ Medicaid Provider # : _____

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PRESCRIBER'S SIGNATURE _____ (DATE) _____ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE

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