HIV ENROLLMENT FORM

Fax To: 817-332-5363

encore pharmacy

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 817-335-5712
Fax: 817-332-5363
800 8th Avenue, Suite 130
Fort Worth, TX 76104

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 _____

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

CD4 Count_____ Date of Lab _____
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 _____
Dates:_____ Drug Name _____
Reason for Discontinuation _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS/SIG*	QTY	REFILLS
COMBINATION ANTIRETROVIRALS				
☐ Biktarvy®	☐ 50/200/25 mg ☐ 30/120/15 mg	Take 1 tablet QD		
☐ Cimduo®	300/300 mg	Take 1 tablet QD		
☐ Cabenuva Injectable Suspension	☐ 600/900 mg ☐ 400/600 mg	☐ _____ _____		
☐ Combivir® (Lamivudine/Zidovudine)	150/300 mg	Take 1 tablet BID		
☐ Complera™	200/25/300 mg	Take 1 tablet QD with food		
☐ Descovy®	☐ 200/25 mg ☐ 120/15 mg	Take 1 tablet QD		
☐ Delstrigo™	100/300/300 mg	Take 1 tablet QD		
☐ Dovato	50/300 mg	Take 1 tablet QD		
☐ Efavirenz/ Emtricitabine/Tenofovir	600/200/300mg	Take 1 tablet QD on an empty stomach		
☐ Epzicom® (Abacavir/ Lamivudine)	600/300 mg	Take 1 tablet QD		
☐ Evotaz™	300/150 mg	Take 1 tablet QD with food		
☐ Genvoya®	150/150/200/10 mg	Take 1 tablet QD with food		
☐ Juluca	50/25 mg	Take 1 tablet QD with food		
☐ Odefsey®	200/25/25 mg	Take 1 tablet QD with food		
☐ Prezcobix™	800/150 mg	Take 1 tablet QD with food		
☐ Stribild®	150/150/200/300 mg	Take 1 tablet QD with food		
☐ Symfi®	600/300/300 mg	Take 1 tablet HS on an empty stomach		
☐ Symfi Lo™	400/300/300 mg	Take 1 tablet HS on an empty stomach		
☐ Tenofovir	600/200/300mg	Take 1 tablet QD on an empty stomach		
☐ Triumeq®	600/50/300 mg	Take 1 tablet QD		
☐ Triumeq PD	60/50/30 mg	Disperse ___ tablets for oral suspension in 20ml of drinking water and give QD		
☐ Trizivir	300/150/300 mg	Take 1 tablet BID		
☐ Truvada®	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg	☐ Take 1 tablet QD ☐ 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		
INTEGRASE INHIBITORS				
☐ Isentress® Chewable	☐ 25mg ☐ 100mg	Chew ____ tablets BID		
☐ Isentress®	400mg	Take 1 tablet BID		
☐ Isentress® HD	600mg	Take 2 tablets QD		
☐ Tivicay®	☐ 10mg ☐ 25mg ☐ 50mg	☐ Take 1 tablet QD ☐ Take 1 tablet BID		
☐ Tivicay PD®	☐ 5mg	☐ Take ____ tablets QD ☐ Disperse ___ tablets for oral suspension in ____mL of drinking water and give QD		

MEDICATION	DOSE/STRENGTH	DIRECTIONS/SIG*	QTY	REFILLS
NRTIs				
☐ Emtriva® (Emtricitabine)	200mg	Take 1 capsule QD		
☐ Emtriva® Oral solution	☐ 10mg/mL	Give ____mg or ____mL QD		
☐ Epivir® (Lamivudine)	☐ 150mg ☐ 300mg			
☐ Epivir® Oral Solution (Lamivudine)	☐ 10mg/mL	Give ____mg or ____mL QD		
☐ Retrovir (Zidovudine)	10 mg/mL	Give ___ mg or ___ mL BID		
☐ Viread® (Tenofovir Disoproxil Fumarate)	☐ 150mg ☐ 200mg ☐ 250mg ☐ 300mg	Take ____mg QD		
☐ Ziagen® (Abacavir)	☐ 300mg			
☐ Zidovudine	☐ 100mg ☐ 300mg	☐ Take 1 tablet QD ☐ Take____ capsule QD		
NNRTIs				
☐ Edurant®	☐ 25mg	Take 1 tablet QD with food		
☐ Intelence® (Etravirine)	☐ 25mg ☐ 100mg	Take ___ tablet(s) BID		
☐ Pifeltro™	100mg	Take 1 tablet QD with or without food		
☐ Sustiva® (Efavirenz)	☐ 50mg ☐ 200mg ☐ 600mg			
☐ Nevirapine	☐ 200mg ☐ ER400mg ☐ 50mg/5mL			
Pharmacokinetic Boosters				
☐ Tybost®	150mg	Take 1 tablet QD		
PROTEASE INHIBITORS				
☐ Aptivus®	250mg	Take 2 tablets BID		
☐ Kaletra® (Lopinavir – Ritonavir)	☐ 100mg/25mg ☐ 200mg/50mg ☐ 80-20mg/ML			
☐ Lexiva® (Fosamprenavir Calcium)	700 mg			
☐ Norvir® (Ritonavir)	☐ 100mg Tablet ☐ 100mg Powder			
☐ Prezista®	☐ 75mg ☐ 150mg ☐ 600mg ☐ 800mg ☐ 100mg/mL			
☐ Reyataz® (Atazanavir)	☐ 150mg ☐ 200mg ☐ 300mg			
FUSION/ENTRY INHIBITORS				
☐ Fuzeon®	90mg vial			
☐ Selzentry® (Maraviroc)	☐ 150mg ☐ 300mg ☐ 20mg/mL			
OTHER				

PRESCRIBERT INFORMATION

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person:_____

Telephone: _____ Fax:_____ Email:_____

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

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

_____ _____ *

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

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.