

HIV Enrollment Form

PATIENT INFORMATION

Patient Name: _____ Phone: (____) - ____ - _____
 Date of Birth: ____ / ____ / ____ Male Female Email: _____
 SSN: ____ - ____ - ____ Preferred method of contact: Phone Email
 Address: _____ Height: ____ in Weight: ____ lb Date: ____ / ____ / ____
 City: _____ State: _____ Zip: _____ Allergies: _____ Medications: _____
 (Please attach additional pages if necessary)

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

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: (____) - ____ - _____ Fax: (____) - ____ - _____
 Address: _____ License #: _____
 City: _____ State: _____ Zip: _____ NPI #: _____
 Contact: _____ Clinic/Hospital Affiliation: _____ Medicaid Provider #: _____

CLINICAL CONSIDERATIONS

Diagnosis:
 B20 HIV Disease
 New to current therapy: Yes No
 CD4 Count: _____ Date: ____ / ____ / ____
 HIV RNA: _____ Date: ____ / ____ / ____
 History of therapies tried/failed (please include dates and reason for discontinuation): _____
 Immunization History
 Influenza
 Date: ____ / ____ / ____

Has patient been tested for:
 Hepatitis C Yes No
 Hepatitis B Yes No
 Test Result: _____

Medication	Strength	Directions	Quantity	Refills
NRTIs				
<input type="checkbox"/> Cimduo™	<input type="checkbox"/> 300/300 mg			
<input type="checkbox"/> Combivir®	<input type="checkbox"/> 150/300 mg			
<input type="checkbox"/> Descovy®	<input type="checkbox"/> 200/25 mg			
<input type="checkbox"/> Emtriva®	<input type="checkbox"/> 200 mg			
<input type="checkbox"/> Epivir®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Epzicom®	<input type="checkbox"/> 600/300 mg			
<input type="checkbox"/> Retrovir®	<input type="checkbox"/> 100 mg			
<input type="checkbox"/> Trizivir®	<input type="checkbox"/> 300/150/300 mg			
<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"/> Videx EC®	<input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 400 mg			
<input type="checkbox"/> Viread®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Zerit®	<input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 40 mg			
<input type="checkbox"/> Ziagen®	<input type="checkbox"/> 300 mg			
NNRTIs				
<input type="checkbox"/> Edurant®	<input type="checkbox"/> 25 mg			
<input type="checkbox"/> Intelence®	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg			
<input type="checkbox"/> Pifeltro™	<input type="checkbox"/> 100 mg			
<input type="checkbox"/> Rescriptor®	<input type="checkbox"/> 200 mg			
<input type="checkbox"/> Sustiva®	<input type="checkbox"/> 50 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 600 mg			
<input type="checkbox"/> Viramune®	<input type="checkbox"/> 200 mg			
<input type="checkbox"/> Viramune XR®	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg			
Pharmacokinetic Boosters				
<input type="checkbox"/> Tyboost®	<input type="checkbox"/> 150 mg			
Integrase Inhibitors				
<input type="checkbox"/> Isentress®	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg			
<input type="checkbox"/> Isentress HD®	<input type="checkbox"/> 600 mg			
<input type="checkbox"/> Tivicay®	<input type="checkbox"/> 10 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg			
<input type="checkbox"/> Vitekta®	<input type="checkbox"/> 150 mg			

Medication	Strength	Directions	Quantity	Refills
Protease Inhibitors				
<input type="checkbox"/> Aptivus®	<input type="checkbox"/> 250 mg			
<input type="checkbox"/> Crixivan®	<input type="checkbox"/> 200 mg <input type="checkbox"/> 400 mg			
<input type="checkbox"/> Evotaz®	<input type="checkbox"/> 300/150 mg			
<input type="checkbox"/> Invirase®	<input type="checkbox"/> 200 mg <input type="checkbox"/> 500 mg			
<input type="checkbox"/> Kaletra®	<input type="checkbox"/> 100/25 mg <input type="checkbox"/> 200/50 mg			
<input type="checkbox"/> Lexiva®	<input type="checkbox"/> 700 mg			
<input type="checkbox"/> Norvir®	<input type="checkbox"/> 100 mg			
<input type="checkbox"/> Prezcobix®	<input type="checkbox"/> 800/150 mg			
<input type="checkbox"/> Prezista®	<input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg			
<input type="checkbox"/> Reyataz®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg			
<input type="checkbox"/> Viracept®	<input type="checkbox"/> 250 mg <input type="checkbox"/> 625 mg			
Combination Antiretrovirals				
<input type="checkbox"/> Atripla®	<input type="checkbox"/> 600/200/300 mg			
<input type="checkbox"/> Biktarvy®	<input type="checkbox"/> 50/200/25 mg			
<input type="checkbox"/> Complera®	<input type="checkbox"/> 200/25/300 mg			
<input type="checkbox"/> Delstrigo™	<input type="checkbox"/> 100/300/300 mg			
<input type="checkbox"/> Dovato®	<input type="checkbox"/> 50/300 mg			
<input type="checkbox"/> Genvoya®	<input type="checkbox"/> 150/150/200/10 mg			
<input type="checkbox"/> Juluca®	<input type="checkbox"/> 50/25 mg			
<input type="checkbox"/> Odefsey®	<input type="checkbox"/> 200/25/25 mg			
<input type="checkbox"/> Stribild®	<input type="checkbox"/> 150/150/200/300 mg			
<input type="checkbox"/> Symfi®	<input type="checkbox"/> 600/300/300 mg			
<input type="checkbox"/> Symfi Lo®	<input type="checkbox"/> 400/300/300 mg			
<input type="checkbox"/> Symtuza®	<input type="checkbox"/> 800/150/200/10 mg			
<input type="checkbox"/> Triumeq®	<input type="checkbox"/> 600/50/300 mg			
Fusion/Entry Inhibitors				
<input type="checkbox"/> Fuzeon®	<input type="checkbox"/> 90 mg vial			
<input type="checkbox"/> Selzentry®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg			

SHIPPING INFORMATION

Ship to: Patient Physician/Clinic Date Shipment Needed By: ____ / ____ / ____