



HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: **888-570-4487** • Fax: **844-899-4226**



1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

ICD-10: _____ Date of Diagnosis: _____ Contraindications: No Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1. CD4/T-cell	_____	_____
2. HIV RNA	_____	_____
3. Viral Load	_____	_____
4. Liver Biopsy	_____	_____

Blood Results:

Date Drawn _____ Hgb/Hct: _____ WBC: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

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

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

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

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength/Directions	QTY	Refills
NRTIs/NNRTIs			
<input type="checkbox"/> DESCOVY® 200/25mg <input type="checkbox"/> EDURANT® 25mg <input type="checkbox"/> EMTRIVA® <input type="checkbox"/> EPIVIR®	<input type="checkbox"/> INTELENCE® <input type="checkbox"/> RESCRIPTOR® <input type="checkbox"/> RETROVIR® <input type="checkbox"/> SUSTIVA®	<input type="checkbox"/> VIDEX® <input type="checkbox"/> VIRAMUNE® <input type="checkbox"/> VIRAMUNE XR® <input type="checkbox"/> VIREAD®	<input type="checkbox"/> ZERIT® <input type="checkbox"/> ZIAGEN®
Protease Inhibitors			
<input type="checkbox"/> APTIVUS® 250mg <input type="checkbox"/> CRIXIVAN® <input type="checkbox"/> EVOTAZ™ 300/150mg	<input type="checkbox"/> INVIRASE® <input type="checkbox"/> KALETRA® 200/50mg <input type="checkbox"/> LEXIVA®	<input type="checkbox"/> PREZISTA® <input type="checkbox"/> REYATAZ® <input type="checkbox"/> VIRACEPT®	<input type="checkbox"/> _____ <input type="checkbox"/> Take 2, twice daily (<input type="checkbox"/> Capsules <input type="checkbox"/> Tablets)
<input type="checkbox"/> NORVIR® 100mg Capsules <input type="checkbox"/> NORVIR® 100mg Tablets			
Combinations			
<input type="checkbox"/> ATRIPLA® 600/200/300mg <input type="checkbox"/> BIKTARVY® 50/200/25mg <input type="checkbox"/> COMBIVIR® 150/300mg <input type="checkbox"/> COMPLERA® 200/25/300mg <input type="checkbox"/> EPZICOM® 600/300mg	<input type="checkbox"/> GENVOYA® 150/150/200/10mg <input type="checkbox"/> JULUCA® 50/25mg <input type="checkbox"/> ODEFSEY® 200/25/25mg <input type="checkbox"/> PREZCOBIX® 800/150mg <input type="checkbox"/> STRIBILD® 150/150/200/300mg	<input type="checkbox"/> SYMTUZA™ 800/150/200/10mg <input type="checkbox"/> TRIUMEQ® 600/50/300mg <input type="checkbox"/> TRIZIVIR® 300/150/300mg <input type="checkbox"/> TRUVADA® 200/300mg	<input type="checkbox"/> Take 1 tablet, once daily <input type="checkbox"/> Take 1 tablet, twice daily <input type="checkbox"/> Take 1 tablet, with a meal daily <input type="checkbox"/> _____
Integrase Inhibitor/CCR5 I			
<input type="checkbox"/> ISENTRESS® 400mg <input type="checkbox"/> SELZENTRY®	<input type="checkbox"/> TIVICAY® 50mg <input type="checkbox"/> VITEKTA®	<input type="checkbox"/> Take 1 tablet, twice daily <input type="checkbox"/> _____	
Supportive Medications			
<input type="checkbox"/> Acyclovir <input type="checkbox"/> Bactrim® (TMC/SMZ) <input type="checkbox"/> Bactrim® DS(TMP/SMZ)	<input type="checkbox"/> Dapsone <input type="checkbox"/> Diflucan® <input type="checkbox"/> Fuzeon®	<input type="checkbox"/> Tybost® <input type="checkbox"/> Valtrex® <input type="checkbox"/> Zithromax®	<input type="checkbox"/> Other <input type="checkbox"/> _____

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

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

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.

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