HIV Enrollment Form

Telephone: 1-888-216-6553;
443-707-6300
Fax: 1-888-216-6802; 410-728-5116
Website: https://totalhealthcarerx.org

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____ NPI #: _____ DEA #: _____
Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ B18.0 Chronic Viral Hepatitis B with Delta Agent
☐ B18.1 Chronic Viral Hepatitis B without Delta-Agent
☐ B18.2 Chronic Viral Hepatitis C
☐ B20 Human Immunodeficiency Virus (HIV) Disease
☐ R64 Cachexia
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

Nursing:

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

5 PRESCRIPTION INFORMATION

Single Regimen Oral:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Biktarvy	☐ 50/200/25 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Complera	☐ 200/25/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Delstrigo	☐ 100/300/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Dovato	☐ 50/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Genvoya	☐ 150/200/150/10 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate* *Brand no longer available for this drug	☐ 600/200/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Juluca	☐ 50/25 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Odefsey	☐ 200/25/25 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Stribild	☐ 150/150/200/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Symfi	☐ 600/300/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Symfi Lo	☐ 400/300/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Symtuza	☐ 800/150/200/10 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Triumeq	☐ 600/50/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Triumeq PD	☐ 60/5/30 mg	☐ Other: _____	Quantity:_____ Refills: _____

☐ Patient is interested in patient support programs

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____	**Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Total Health Care Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Single Regimen Injectable:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cabenuva 600/900 mg Injection Kit	☐ 600/900 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Cabenuva 400/600 mg Injection Kit	☐ 400/600 mg	☐ Other: _____	Quantity:_____ Refills: _____

NRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cimduo	☐ 300/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Combivir	☐ 150/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Descovy	☐ 200/25 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Emtriva	☐ 200 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Epivir	☐ 150 mg ☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Epzicom	☐ 600/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Retrovir	☐ 100 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Temixys	☐ 300/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Trizivir	☐ 300/150/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Truvada	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Videx EC	☐ 125 mg ☐ 200 mg ☐ 250 mg ☐ 400 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Viread	☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Zerit	☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Ziagen	☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Zidovudine	☐ 100 mg ☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____

NNRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Edurant	☐ 25 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Intelence	☐ 25 mg ☐ 100 mg ☐ 200 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Pifeltro	☐ 100mg tablet	☐ Take once daily with or without food	Quantity:_____ Refills: _____
☐ Sustiva	☐ 50 mg ☐ 200 mg ☐ 600 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Viramune	☐ 200 mg ☐ 50 mg/ 5 mL	☐ Other: _____	Quantity:_____ Refills: _____
☐ Viramune XR	☐ 100 mg ☐ 400 mg	☐ Other: _____	Quantity:_____ Refills: _____

Integrase Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Apretude Injection Kit	☐ 600 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Isentress	☐ 400 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Isentress HD	☐ 600 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Tivicay	☐ 10 mg ☐ 25 mg ☐ 50 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Tivicay PD	☐ 5 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Vocabria	N/A	All referrals must be sent through the HUB, ViiV Connect. Phone: 1-844-588-3288; Fax 1-844-208-7676	N/A

☐ Patient is interested in patient support programs

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____ Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Total Health Care Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Protease Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aptivus	☐ 250 mg ☐ 100 mg/mL	☐ Other: _____	Quantity:_____ Refills: _____
☐ Crixivan	☐ 200 mg ☐ 400 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Evotaz	☐ 300/150 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Invirase	☐ 200 mg ☐ 500 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL	☐ Other: _____	Quantity:_____ Refills: _____
☐ Lexiva	☐ 700 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Norvir	☐ 100 mg ☐ 80 mg/mL	☐ Other: _____	Quantity:_____ Refills: _____
☐ Prezcobix	☐ 800/150 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Prezista	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Reyataz	☐ 150 mg ☐ 200 mg ☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____
☐ Viracept	☐ 250 mg ☐ 625 mg	☐ Other: _____	Quantity:_____ Refills: _____

Entry Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Fuzeon	☐ 90 mg vial	☐ Other: _____	Quantity:_____ Refills: _____
☐ Selzentry	☐ 150 mg ☐ 300 mg	☐ Other: _____	Quantity:_____ Refills: _____

Pharmacokinetic Enhancer:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tybost	☐ 150 mg	☐ Other: _____	Quantity:_____ Refills: _____

Miscellaneous:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Bactrim	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills: _____
☐ Diflucan	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills: _____
☐ Egrifta SV	NA	All referrals must be sent through the HUB, Egrifta Assist. Phone: 1-844-EGRIFTA or 1-844-347-4382; Fax 1-855-836-3069	Quantity: 0 Refills: 0
☐ Mytesi	125 mg tablet	☐ Take twice daily with or without food	Quantity:_____ Refills: _____
☐ Rukobia	600 mg Extended-Release	☐ Other: _____	Quantity:_____ Refills: _____
☐ Serostim	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills: _____
☐ Trogarzo	NA	All referrals must be sent through the HUB, Trogarzo Assist. Phone: 1-(833)-238-4372 Fax 1-(855)-836-3069	Quantity: 0 Refills: 0

Other:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Total Health Care Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.