HIV Enrollment Form

Fax Referral To: 1-718-261-6689
Email Referral To: info@healthycornerpharmacy.com
Phone: 1-855-261-6699

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

Patient Name: _____
Address: _____City, State, ZIP: _____
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: _____DOB: _____
Gender: ☐ Male ☐ Female Email: _____
Last Four of SSN: _____Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____ DEA #: _____
Group or Hospital: _____ Address: _____
City, State, ZIP: _____
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 _____

For additional ICD-10 information, please visit www.icd10-data.com

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

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 below, I hereby authorize Healthy Corner 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 Tablet Regimens:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Atripla®	☐ 600/200/300 mg	☐ Other: _____	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: ____
☐ 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: ____

NRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	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: ____
☐ 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 XR®	☐ 100 mg ☐ 400 mg	☐ Other: _____	Quantity:____ Refills: ____

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

6 PHYSICIAN SIGNATURE REQUIRED

DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

X_____ X_____

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 below, I hereby authorize Healthy Corner 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

Integrase Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Isentress®	☐ 400 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Isentress HD®	☐ 600 mg	☐ Other: _____	Quantity:____ Refills: ____
☐ Tivicav®	☐ 50 mg	☐ Other: _____	Quantity:____ Refills: ____

Protease Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Evotaz®	☐ 300/150 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: ____
☐ 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 Enhancers:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Norvir®	☐ 100 mg ☐ 80 mg/mL	☐ Other: _____	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®	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
☐ 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 PHYSICIAN SIGNATURE REQUIRED

DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

X_____ X_____

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 below, I hereby authorize Healthy Corner 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.