HIV Enrollment Form

Date:_____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Clinical Info

Please include hard copies of viral load and pertinent office visit notes to expedite prior authorization process.

Diagnosis: ❑ B20 HIV ❑ Other _____ ICD 10 code: _____

HIV RNA: _____ Date: _____

Prescription

Medication

❑ **Atripla® (EFV/FTC/TDF) 600/200/300 mg**
One tablet by mouth once daily on an empty stomach

❑ **Biktarvy® (BIC/FTC/TAF) 50/200/25 mg**
One tablet by mouth once daily

❑ **Combivir® (lamivudine/zidovudine) 150/300 mg**
One tablet by mouth twice daily

❑ **Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg**
One tablet by mouth once daily with food

❑ **Crixivan® (indinavir) 400 mg**
Two capsules (800 mg) by mouth every 8 hours on an empty stomach

❑ **Descovy® (FTC/TAF) 200/25 mg**
One tablet by mouth once daily

❑ **Edurant™ (rilpivirine) 25 mg**
One tablet by mouth once daily with food

❑ **Emtriva® (emtricitabine) 200 mg**
One capsule by mouth once daily

❑ **Epivir® (lamivudine) 150 mg**
❑ One tablet by mouth twice daily
❑ Two tablets (300 mg) by mouth once daily

❑ **Epzicom® (abacavir/lamivudine) 600/300 mg**
One tablet by mouth once daily

❑ **Evotaz® (atazanavir/cobicistat) 300/150 mg**
One tablet by mouth once daily with food

❑ **Fuzeon® (enfuvirtide) 90 mg**
Inject 90 mg (1 mL) SQ twice daily

❑ **Genvoya® (elvitegravir, cobicistat, FTC, TAF) 150/150/200/10 mg**
One tablet by mouth once daily with food

❑ **Intelence® (etravirine) 100 mg**
Two tablets by mouth twice daily following a meal

❑ **Intelence® (etravirine) 200 mg**
One tablet by mouth twice daily following a meal

❑ **Invirase® (saquinavir) 500 mg**
Two tablets by mouth twice daily (in combination with ritonavir)

❑ **Isentress® (raltegravir) 400 mg**
One tablet by mouth twice daily

❑ **Isentress® HD (raltegravir) 600 mg**
Two tablets by mouth once daily

❑ **Norvir® (ritonavir) 100 mg tablets**
Take _____ tablet by mouth _____ daily

❑ **Odefsey® (FTC/RPV/TAF) 200/25/25 mg**
One tablet by mouth once daily with a meal

❑ **Prezista® (darunavir) 400 mg**
Two tablets by mouth once daily with food

❑ **Prezista® (darunavir) 600 mg**
One tablet by mouth twice daily with food

❑ **Prezista® (darunavir) 800 mg**
One tablet by mouth once daily with food

❑ **Retrovir® (zidovudine) 300 mg**
One tablet by mouth twice daily

❑ **Reyataz® (atazanavir) 300 mg**
One capsule by mouth once daily with food

❑ **Stribild™ (EVG/COBI/FTC/TDF)**
150/150/200/300 mg
One tablet by mouth once daily with food

❑ **Sustiva® (efavirenz) 600 mg**
One tablet by mouth once daily on an empty stomach

❑ **Tivicay® (dolutegravir) 50 mg**
❑ One tablet by mouth once daily
❑ One tablet by mouth twice daily

❑ **Triumeq® (abacavir, dolutegravir, lamivudine) 600/50/300 mg**
One tablet by mouth once daily

❑ **Trizivir® (abacavir/lamivudine/zidovudine) 300/150/300 mg**
One tablet by mouth twice daily

❑ **Truvada® (FTC/TDF) 200/300 mg**
One tablet by mouth once daily

❑ **Viracept® (nelfinavir) 250 mg**
❑ 5 tablets (1250 mg) by mouth twice daily with food
❑ 3 tablets (750 mg) by mouth three times daily with food

❑ **Viracept® (nelfinavir) 625 mg**
2 tablets (1250 mg) by mouth twice daily with food

❑ **Viread® (TDF) 150 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 200 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 250 mg**
One tablet by mouth once daily

❑ **Viread® (TDF) 300 mg**
One tablet by mouth once daily

❑ **Ziagen® (abacavir) 300 mg**
❑ One tablet by mouth twice daily
❑ Two tablets (600 mg) by mouth once daily

❑ **Other** _____

_____

❑ **All prescriptions will be dispensed quantity sufficient for 30 days. Refills_____**

Is patient new to this therapy? ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
Practice Name: _____ Contact: _____ Preferred Method: ❑ Phone ❑ Fax ❑ Email
Address: _____ Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.