

# HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**



## 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
<b>NRTIs/NNRTIs</b>			
<input type="checkbox"/> DESCOVY® 200/25mg <input type="checkbox"/> INTELENCE® <input type="checkbox"/> VIDEX® <input type="checkbox"/> ZERIT® <input type="checkbox"/> EDURANT® 25mg <input type="checkbox"/> RESCRIPTOR® <input type="checkbox"/> VIRAMUNE® <input type="checkbox"/> ZIAGEN® <input type="checkbox"/> EMTRIVA® <input type="checkbox"/> RETROVIR® <input type="checkbox"/> VIRAMUNE XR® <input type="checkbox"/> EPIVIR® <input type="checkbox"/> SUSTIVA® <input type="checkbox"/> VIREAD®			
<b>Protease Inhibitors</b>			
<input type="checkbox"/> APTIVUS® 250mg <input type="checkbox"/> INVIRASE® <input type="checkbox"/> PREZISTA® <input type="checkbox"/> CRIVIVAN® <input type="checkbox"/> KALETRA® 200/50mg <input type="checkbox"/> REYATAZ® <input type="checkbox"/> EVOTAZ™ 300/150mg <input type="checkbox"/> LEXIVA® <input type="checkbox"/> VIRACEPT®	<input type="checkbox"/> _____ <input type="checkbox"/> Take 2, twice daily ( <input type="checkbox"/> Capsules <input type="checkbox"/> Tablets)		
<b>Combinations</b>			
<input type="checkbox"/> ATRIPLA® 600/200/300mg <input type="checkbox"/> GENVOYA® 150/150/200/10mg <input type="checkbox"/> SYMTUZA™ 800/150/200/10mg <input type="checkbox"/> BIKTARVY® 50/200/25mg <input type="checkbox"/> JULUCA® 50/25mg <input type="checkbox"/> TRIUMEQ® 600/50/300mg <input type="checkbox"/> COMBIVIR® 150/300mg <input type="checkbox"/> ODEFSEY® 200/25/25mg <input type="checkbox"/> TRIZIVIR® 300/150/300mg <input type="checkbox"/> COMPLERA® 200/25/300mg <input type="checkbox"/> PREZCOBIX® 800/150mg <input type="checkbox"/> TRUVADA® 200/300mg <input type="checkbox"/> EPZICOM® 600/300mg <input type="checkbox"/> STRIBILD® 150/150/200/300mg	<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"/> _____		
<b>Integrase Inhibitor/CCR5 I</b>			
<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"/> _____		
<b>Supportive Medications</b>			
<input type="checkbox"/> Acyclovir <input type="checkbox"/> Dapsone <input type="checkbox"/> Tybost® <input type="checkbox"/> Other <input type="checkbox"/> Bactrim® (TMC/SMZ) <input type="checkbox"/> Diflucan® <input type="checkbox"/> Valtrex® <input type="checkbox"/> Bactrim® DS(TMP/SMZ) <input type="checkbox"/> Fuzeon® <input type="checkbox"/> Zithromax®			

**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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