

HIV Prescription Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821

1. Patient Information

Start Date: _____ Ship to: ___ Patient ___ Office _____ Other

Patient Name: _____ M / F DOB: _____ SSN: _____

Address: _____ Phone #: _____

Caregiver: _____ Allergies: _____ Alt Phone #: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information *please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code: _____ Prior Therapy: _____

New to current therapy? Yes / No CD4: _____ Date: _____ HIV RNA: _____ Date: _____

3. Prescription Information *if your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

Please fax a list of patient's other medications and choose packaging: _____ AccuPAC® Bottles Check to learn more about AccuPAC®

X	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Aptivus®	__ 250 mg ____ (with Norvir®)	__ Take 2 caps by mouth 2x a day (Q12H)	____ gel cap	
	Atripla®	__ 600/200/300 mg	__ Take 1 tab by mouth every day (empty stomach)	____ tabs	
	Combivir®	__ 150/300 mg	__ Take 1 tab by mouth 2x a day (Q12H)	____ tabs	
	Complera®	__ 200/25/300 mg	__ Take 1 tab by mouth every day w/food	____ tabs	
	Crixivan®	__ 400 mg	__ Take 1 cap by mouth every day w/food	____ caps	
	Edurant®	__ 25 mg	__ Take 1 tab by mouth every day w/food	____ tabs	
	Emtriva®	__ 200 mg	__ Take 1 cap by mouth every day	____ caps	
		__ 10 mg/ mL oral solution	__ Take 24 mL every day	__ 170 mL	
	Epivir®	__ 150 mg ____ 300 mg	__ Take ____ tabs ____ times per day	____ tabs	
	Epzicom®	__ 600/300 mg	__ Take 1 tab by mouth every day	____ tabs	
	Evotaz®	__ 300/150 mg	__ Take 1 tab by mouth every day w/food	____ tabs	
	Fuzeon®	__ 90 mg injection	__ Inject 1mL Sub-Q 2x a day (Q12H)	__ 60 _(1mL) vials	
	Genvoya®	__ 150/150/200/10 mg	__ Take 1 tab by mouth every day w/food	____ tabs	
	Intelence®	__ 100 mg ____ 200 mg	__ Take ____ tabs 2x a day, following a meal	____ tabs	
	Invirase®	__ 500 mg	__ Take ____ tabs ____ times per day	____ tabs	
	Isentress®	__ 100 mg chewable ____ 100 mg pkt	__ Take ____ mg by mouth every day	____ tabs	
		__ 400 mg tab ____ 600 mg tab	__	__ 60 pkts	
	Juluca®	__ 50/25 mg	__ Take 1 tablet by mouth every day	____ tabs	
	Kaletra®	__ 100/25 mg ____ 200/50 mg	__ Take ____ tabs ____ times per day	____ tabs	
		__ 400/100 mg/5 mL	__ Take ____ mL ____ times per day	____ mL	
	Lexiva®	__ 700 mg	__ Take ____ tabs ____ times per day	____ tabs	
		__ 50 mg/mL oral suspension	__ Take ____ mL ____ times per day	____ mL	
	Mepron®	__ 750 mg/5mL	__ Take ____ mL ____ times per day	____ mL	

Norvir®	<input type="checkbox"/> 100 mg <input type="checkbox"/> 80 mg/mL solution	<input type="checkbox"/> Take <input type="text"/> tabs <input type="text"/> times per day <input type="checkbox"/> Take <input type="text"/> mL <input type="text"/> times per day	<input type="text"/> tabs <input type="text"/> 240 mL
Odefsey®	<input type="checkbox"/> 200/25/25 mg	<input type="checkbox"/> Take 1 tab by mouth every day w/food	<input type="text"/> tabs
Prezcobix®	<input type="checkbox"/> 800/150 mg	<input type="checkbox"/> Take 1 tab by mouth every day w/food	<input type="text"/> tabs
Prezista®	<input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg	<input type="checkbox"/> Take <input type="text"/> tabs <input type="text"/> times per day w/food	<input type="text"/> tabs
Rescriptor®	<input type="checkbox"/> 200 mg	<input type="checkbox"/> Take 2 tabs by mouth 3x a day	<input type="text"/> tabs
Retrovir®	<input type="checkbox"/> 100 mg <input type="checkbox"/> 50 mg/5mL syrup	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day <input type="checkbox"/> Take <input type="text"/> mL by mouth <input type="text"/> times per day	<input type="text"/> caps <input type="text"/> mL
Reyataz®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 50 mg pkt	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day	<input type="text"/> caps <input type="text"/> pkts
Selzentry®	<input type="checkbox"/> 25 mg <input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 20 mg/mL solution	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day <input type="checkbox"/> Take <input type="text"/> mL <input type="text"/> times per day	<input type="text"/> tabs <input type="text"/> mL
Stribild®	<input type="checkbox"/> 150/150/200/300 mg	<input type="checkbox"/> Take 1 tab by mouth every day w/food	<input type="text"/> tabs
Sustiva®	<input type="checkbox"/> 50 mg cap <input type="checkbox"/> 200 mg cap <input type="checkbox"/> 600mg tab	<input type="checkbox"/> Take <input type="text"/> mg by mouth at bedtime	<input type="text"/> tabs <input type="text"/> caps
Tivicay®	<input type="checkbox"/> 50 mg	<input type="checkbox"/> Take 1 tab by mouth <input type="text"/> times per day	<input type="text"/> tabs
Trizivir®	<input type="checkbox"/> 300/150/300 mg	<input type="checkbox"/> Take 1 tab by mouth 2x a day (Q12H)	<input type="text"/> tabs
Triumeq®	<input type="checkbox"/> 600/50/300 mg	<input type="checkbox"/> Take 1 tab by mouth every day	<input type="text"/> tabs
Truvada®	<input type="checkbox"/> 100/150 mg <input type="checkbox"/> 200/300 mg	<input type="checkbox"/> Take 1 tab by mouth every day	<input type="text"/> tabs
Tybost®	<input type="checkbox"/> 150 mg	<input type="checkbox"/> Take 1 tab by mouth every day	<input type="text"/> tabs
Videx®EC	<input type="checkbox"/> 125 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day	<input type="text"/> caps
Viracept®	<input type="checkbox"/> 250 mg <input type="checkbox"/> 625 mg	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day	<input type="text"/> tabs <input type="text"/> tabs
Viramune®	<input type="checkbox"/> 200 mg <input type="checkbox"/> 50 mg / 5 mL Suspension	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day <input type="checkbox"/> Take <input type="text"/> mL mouth every day	<input type="text"/> 60 tabs <input type="text"/> 240 mL
Viramune XR®	<input type="checkbox"/> 400 mg	<input type="checkbox"/> Take 1 tab by mouth every day	<input type="text"/> 30 tabs
Viread®	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 40 mg/scoop powder	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day	<input type="text"/> 30 tabs <input type="text"/> 60 grams
Zerit®	<input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 1 mg/ mL oral solution	<input type="checkbox"/> Take <input type="text"/> mg by mouth <input type="text"/> times per day <input type="checkbox"/> Take <input type="text"/> mL by mouth <input type="text"/> times per day	<input type="text"/> caps <input type="text"/> mL
Ziagen®	<input type="checkbox"/> 300 mg <input type="checkbox"/> 20mg / mL solution	<input type="checkbox"/> Take <input type="text"/> mg <input type="text"/> times a day <input type="checkbox"/> Take <input type="text"/> mL by mouth <input type="text"/> times per day	<input type="text"/> tabs <input type="text"/> mL

4. Prescriber and Shipping Information

Preferred Method of Contact: phone fax email

Prescriber (print): _____ Office Contact: _____

Phone: _____ Contact email: _____ Fax: _____

Office Address: _____ NPI: _____

Prescriber's Signature: _____ Date: _____ DEA: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information Please fax a copy of insurance card front and back. Enlarge if possible.

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