Express Health Mart Pharmacy
1173 Nostrand ave,
Brooklyn, NY 11225

HIV Co-Infection Enrollment Form

Date: _____ **Needs by Date:** _____

Tel: 347-221-1100
E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com
www.expresshealthmart.com

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD -9 code):

☐ 042 HIV / AIDS
☐ 070.54 Hepatitis C (chronic)
☐ 070.32 Hepatitis B
☐ 799.4 Cachexia (HIV Wasting)
• Date of Diagnosis: _____

Patient Evaluation – HIV:

Lab Data:	lab v.	baseline	current
CD4/T-cell count:			
HIV RNA:			
Hgt/Hct:			
White blood cell ct:			

Patient Evaluation – Hep C:

• HCV RNA (Baseline) _____ IU/ml • Date of Lab: _____
• HCV RNA (12 weeks, if applicable) _____ IU/ml • Date of Lab: _____
• HCV Genotype: ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6 • Pre-Treatment _____
• Has patient been previously treated for Hepatitis C? ☐ Yes ☐ No
• Has patient had liver biopsy? ☐ Yes ☐ No • Biopsy date/Results: _____
• Does patient suffer from uncontrolled/life-threatening neuropsychiatric, autoimmune, ischemic, or infectious disorders, or have a history of autoimmune hepatitis or hepatic decompensation? ☐Y ☐N
• If taking ribavirin, is the patient (or patient's partner) pregnant or unwilling to use adequate contraception, or is there a history of hemoglobinopathies or renal insufficiency (crcl<50ml/min)? ☐Y ☐N

Other Clinical Information:

• Concomitant Medications: _____
• Allergies: _____ • Patient Weight: _____ kg/lbs
• Patient Height: _____ in/cm • Length of proposed treatment: _____

Injection Training/Home Health Coordination:

• Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. ☐Yes ☐No *Agency of choice: _____
• Injection training is not necessary. Date training occurred: _____
Reason: ☐MD office trained patient ☐Patient already independent ☐Referred by MD office to alternate trainer

PRESCRIPTION INFORMATION

HIV MEDICATIONS

MEDICATION	STRENGTH	DIRECTIONS/SIG	QTY	REFILL
☐ Aptivus®	250 mg			
☐ Atripla®	300/200/600			
☐ Combivir®	300/150			
☐ Complera®	300/200/25			
☐ Crixivan®				
☐ Emtriva®	200mg			
☐ Epivir®				
☐ Epzicom®	600/300			
☐ Fuzeon®	90 mg vial kit			
☐ Intelence®	100mg			
☐ Invirase®				
☐ Isentress®	400mg			
☐ Kaletra®	200/50			
☐ Lexiva®	700 mg			
☐ Norvir® tablet	100 mg			
☐ Prezista®				
☐ Rescriptor®				
☐ Retrovir®				
☐ Reyataz®				
☐ Selzentry®				
☐ Sustiva®				
☐ Trizivir®	300/150/300			
☐ Truvada®	300/200			
☐ Videx®				
☐ Viracept®				

HIV MEDICATIONS (CONTINUED)

MEDICATION	STRENGTH	DIRECTIONS/SIG	QTY	REFILL
☐ Viramune®				
☐ Viread®	300 mg			
☐ Zerit®				
☐ Ziagen®				

HEPATITIS C MEDICATIONS

☐ Pegasys®	180 mcg			
*Please indicate conv. Pack (includes injection supplies) ☐ Prefilled Syringe ☐ Vial				
☐ Pegasys® ProClick Autoinjector	180ug/0.5 ml	Inject 180ug subcutaneously once a week as directed		
☐ Pegasys® ProClick Autoinjector	135ug/0.5 ml	Inject 135ug subcutaneously once a week as directed		
☐ PegIntron™				
*Please indicate kit (includes injection supplies) ☐ Redipen® ☐ Vial				
☐ Ribavirin caps	200 mg			
☐ Ribavirin tabs	200 mg			
☐ Infergen®				

HEPATITS B MEDICATIONS

☐ Baraclude®				
☐ Epivir HBV®	100mg			
☐ Hepsera®	10mg			
☐ Tyzeka®	600mg			
☐ Viread®				

OTHER MEDICATIONS

☐ Egrifta®	All Egrifta prescriptions must go through the Axis Center. Please contact Axis Center at 1-877-714-2947.			
☐ Serostim®				
☐				

Ancillary Supplies and Kits Provided As Needed for Administration

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)