HIV Enrollment Form

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6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Primary Phone: __________ DOB: __________
Alternate Phone: __________ Gender: ☐Male ☐Female
E-mail: ____________________
Last Four of SS #: ______ Primary Language: __________

2 PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ NPI #: __________
DEA #: ____________________
Group or Hospital: ____________________
Address: ____________________
City, State Zip: ____________________
Phone: __________ Fax: __________
Contact Person: __________ 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: __________ Date of Diagnosis: __________

Diagnosis (ICD -9 code):

☐ 042 HIV / AIDS
☐ 070.54 Hepatitis C (chronic)
☐ 070.32 Hepatitis B
☐ 799.4 Cachexia (HIV Wasting)
☐ Other: __________
Date of diagnosis: __________

Injection Training/Home Health Coordination:

Specialty Pharmacy to coordinate subcutaneous training for:

☐ Fuzeon
☐ Egrifta
☐Serostim

Patient Evaluation:

Allergies/ Comments: ____________________
Concomitant Medications: ____________________
Weight: ______ kg/lbs Height: ______ Inches BMI ______

☐Naïve to Treatment Therapy ☐Experienced to Treatment Therapy

Lab Data:	Lab Value	Baseline	Current
CD4/T-cell count:			
HIV RNA:			
Hgb/Hct:			
White blood cell count:			

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
NRTIS				
☐ Edurant™				
☐ Emtriva®	200mg			
☐ Epivir®				
☐ Retrovir®				
☐ Videx EC®				
☐ Viread®	300mg			
☐ Zerit®				
☐ Ziagen®				
NRTIS				
☐ Intelence®	100mg			
☐ Rescriptor®				
☐ Sustiva®				
☐ Viramune XR®				
COMBINATION ANTIRETROVIRALS				
☐ Atripla®	300/200/600			
☐ Combivir®	300/150			
☐ Complera®	300/200/25			
☐ Epzicom®	600/300			
☐ Stribild™	150/150/200/300			
☐ Trizivir®	300/150/300			
☐ Truvada®	300/200			
INTEGRASE INHIBITORS				
☐ Isentress®	400mg			

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
PROTEASE INHIBITORS				
☐ Aptivus®	250 mg			
☐ Crixivan®				
☐ Invirase®				
☐ Kaletra®	200/50			
☐ Lexiva®	700 mg			
☐ Norvir® tablet	100 mg			
☐ Prezista®				
☐ Reyataz®				
☐ Viracept®				
ENTRY INHIBITORS				
☐ Fuzeon®	90mg vial			
☐ Selzentry®				
☐				
☐				
OTHER MEDICATIONS				
☐ Bactrim®				
☐ Diflucan®				
☐ Egrifta®	All Egrifta prescriptions must go through the Axis Center. Please contact Axis Center at 1-877-714-2947.			
☐ Procrit®				
☐ Serostim®				
☐				
☐				
☐				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6

PHYSICIAN SIGNATURE REQUIRED

X ______________________________ X ______________________________

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

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. HIV 043013