briovaRx®

Fax:

Phone:

HIV Enrollment Form

PATIENT INFORMATION

Patient Name _____

Address _____

City, State, Zip _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number:

MEDICAL INFORMATION (Section must be completed to process prescription) *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

ICD-10 ☐ B20 Human immunodeficiency virus [HIV] ☐ Other _____

Date of diagnosis _____ _____

Patient Evaluation

Allergies/Comments _____

Concomitant Medications _____

Weight _____ kg/lbs Height _____ cm/in BMI _____

Hep B test completed? ☐ Yes ☐ No

☐ Naïve to Treatment Therapy ☐ Experienced to Treatment Therapy

Injection Training Required? ☐ Yes ☐ No

Lab Data	Lab Value	Baseline	Current
CD4/T-cell Count			
HIV RNA			
Hgb/Hct			
White Blood cell count			
Creatinine Clearance			

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
☐ Aptivus	☐ 250 mg capsule ☐ 100 mg/mL solution			
☐ Atripla	☐ 600/200/300 mg tablet			
☐ Biktarvy	☐ 50/200/25 mg tablet			
☐ Cimduo	☐ 300/300 mg tablet			
☐ Combivir	☐ 150/300 mg tablet			
☐ Complera	☐ 200/25/300 mg tablet			
☐ Crixivan	☐ 200 mg capsule ☐ 400 mg capsule			
☐ Delstrigo	☐ 100/300/300 mg tablet			
☐ Descovy	☐ 200/25 mg tablet			
☐ Edurant	☐ 25 mg tablet			
☐ Emtriva	☐ 200 mg capsule ☐ 10 mg/mL solution			
☐ Epivir	☐ 150 mg tablet ☐ 300 mg tablet ☐ 10 mg/mL solution			
☐ Epzicom	☐ 600/300 mg tablet			
☐ Evotaz	☐ 300/150 mg tablet			
☐ Fuzeon	☐ 90 mg vial			
☐ Genvoya	☐ 150/150/200/10 mg tablet			
☐ Intelence	☐ 25 mg tablet ☐ 100 mg tablet ☐ 200 mg tablet			
☐ Invirase	☐ 200 mg capsule ☐ 500 mg tablet			
☐ Isentress	☐ 25 mg chewable tablet ☐ 100 mg chewable tablet ☐ 100 mg granules for suspension ☐ 400 mg tablet			
☐ Isentress HD	☐ 600 mg tablet			
☐ Juluca	☐ 50/25 mg tablet			
☐ Kaletra	☐ 100/25 mg tablet ☐ 200/50 mg tablet ☐ 80-20 mg/mL solution			
☐ Lamivudine/ nevirapine/zidovudine	☐ 150/200/300 mg tablet			
☐ Lexiva	☐ 700 mg tablet ☐ 50 mg/mL suspension			
☐ Norvir	☐ 100 mg tablet ☐ 100 mg capsule ☐ 100 mg powder ☐ 80 mg/mL solution			
☐ Odefsey	☐ 200/25/25 mg tablet			
☐ Pifeltro	☐ 100 mg tablet			
☐ Prezcobix	☐ 800/150 mg tablet			
☐ Prezista	☐ 75 mg tablet ☐ 150 mg tablet ☐ 600 mg tablet ☐ 800 mg tablet ☐ 100 mg/mL suspension			

Medication	Dose/Strength	Directions	Qty	Refills
☐ Rescriptor	☐ 100 mg tablet ☐ 200 mg tablet			
☐ Retrovir	☐ 100 mg capsule ☐ 300 mg tablet ☐ 50 mg/5mL syrup ☐ 10 mg/mL vial			
☐ Reyataz	☐ 150 mg capsule ☐ 200 mg capsule ☐ 300 mg capsule ☐ 50 mg oral powder			
☐ Selzentry	☐ 25 mg tablet ☐ 75 mg tablet ☐ 150 mg tablet ☐ 300 mg tablet ☐ 20 mg/mL solution			
☐ Stribild	☐ 150/150/200/300 mg tablet			
☐ Sustiva	☐ 50 mg capsule ☐ 200 mg capsule ☐ 600 mg tablet			
☐ Symfi	☐ 600/300/300 mg tablet			
☐ Symfi Lo	☐ 400/300/300 mg tablet			
☐ Symtuza	☐ 800/150/200/10 mg tablet			
☐ Tivicay	☐ 10 mg tablet ☐ 25 mg tablet ☐ 50 mg tablet			
☐ Triumeq	☐ 600/50/300 mg tablet			
☐ Trizivir	☐ 300/150/300 mg tablet			
☐ Truvada	☐ 100/150 tablet ☐ 133/200 tablet ☐ 167/250 tablet ☐ 200/300 tablet			
☐ Tybost	☐ 150 mg tablet			
☐ Videx	☐ 2 g powder for solution ☐ 4 g powder for solution			
☐ Videx EC	☐ 125 mg delayed-release capsule ☐ 200 mg delayed-release capsule ☐ 250 mg delayed-release capsule ☐ 400 mg delayed-release capsule			
☐ Viracept	☐ 250 mg tablet ☐ 625 mg tablet			
☐ Viramune	☐ 200 mg tablet ☐ 50 mg/5 mL suspension			
☐ Viramune XR	☐ 100 mg extended-release tablet ☐ 400 mg extended-release tablet			
☐ Viread	☐ 150 mg tablet ☐ 200 mg tablet ☐ 250 mg tablet ☐ 300 mg tablet ☐ 40 mg/scoop oral powder			
☐ Zerit	☐ 15 mg capsule ☐ 20 mg capsule ☐ 30 mg capsule ☐ 40 mg capsule			
☐ Ziagen	☐ 20 mg/mL solution ☐ 300 mg tablet			

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature:_____ Date:_____