HIV/AIDS
Enrollment Form

Phone: 844-309-7172
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient	DOB	SSN# Patient Height_____ (inches) Weight _____ (lbs)	
Address		City	State / Zip
Phone # (Home)		(Work)	Email address
Caregiver	(Phone)	Emergency Contact	(Phone)

2. INSURANCE INFORMATION

Primary Insurance Rx insurance: BIN _____ PCN:_____		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

3. DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses)

☐ B20 Human Immunodeficiency Virus (HIV infection)	Date of Diagnosis	
Viral Load Date	CD4 count Date	
☐ Chronic Viral hepatitis	HBV?	HCV?

4. PREVIOUS MEDICATIONS (Please specify dosage & time on therapy)

Medication Strength & Dose	Dates of Therapy	Reason for Discontinuing

5. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Atripla® (efavirenz-emtricitabine-tenofovir)	1 pill	At bedtime on empty stomach	30	
☐ Biktarvy® (bictegravir-emtricitabine-tenofovir-alafenamide)	1 pill	Once daily w/ or w/o food	30	
☐ Complera® (emtricitabine-rilpivirine-tenofovir)	1 pill	Once daily with a MEAL	30	
☐ Genvoya® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	1 pill	Once daily with food/snack	30	
☐ Juluca (dolutegravir and rilpivirine)	1 pill	Once daily with a MEAL	30	
☐ Odefsey® (emtricitabine-rilpivirine-tenofovir)	1 pill	Once daily with a MEAL	30	
☐ Stribild® (elvitegravir-cobicistat-emtricitabine-tenofovir)	1 pill	Once daily with food/snack	30	
☐ Symutza (darunavir-cobicistat-emtricitabine-tenofovir alafenamide)	1 pill	Once daily with food/snack	30	
☐ Triumeq® (abacavir-dolutegravir-lamivudine)	1 pill	Once daily w/ or w/o food	30	
☐ Other				
☐ Other				

6. DELIVERY INSTRUCTIONS

☐ Physicians Office	☐ Other	Date Medication Needed
☐ Patient's Home	Address	
	City/State/Zip	

7. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	E-Mail
Address	City/State/Zip	
License #	NPI #	

Physician's Signature _____ PHYSICIAN SIGNATURE REQUIRED –stamp signature not allowed **Date** _____

(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.