Sunray Specialty Pharmacy

HIV Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: ______________________
Address: ______________________
City, State, Zip Code: ______________________
Home Phone: ______________________
Alternate Phone: ______________________
DOB: ______________
Last 4 Digits of SS#: ______________
Gender: ______________
Language Preference: ______________

PRESCRIBER INFORMATION:

Prescriber's Name: ______________________
DEA: ______________________
NPI: ______________________
Address: ______________________
City, State, Zip Code: ______________________
Phone: ______________________
Fax: ______________________
Contact Person: ______________________
Contact Person's Phone: ______________________

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: ______________

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

- ☐ B18.1 Chronic viral hepatitis B without delta-agent
- ☐ B18.2 Chronic viral hepatitis C
- ☐ B20 Human immunodeficiency virus (HIV)
- ☐ R64 Cachexia

Other Diagnosis:
ICD-10 Code: ______________
Description: ______________________
Date of Diagnosis: ______________

Additional information:

Therapy: ☐ Naïve ☐ Experienced
Weight: ________ kg/lb Height ________ cm/in BMI __________
Allergies: ______________________
Concomitant Medications: ______________________

Lab Data	Lab Value	Baseline	Current
CD4/T-cell Count			
HIV RNA			
Hgb/HCT			
WBC			
CrCl			

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Qty	Refills
Combination Antiretrovirals				
Atripla®	☐ 300/200/600			
Biktarvy®	☐ 50/200/25			
Cimduo™	☐ 300/300			
Combivir®	☐ 300/150			
Complera®	☐ 300/200/25			
Epzicom®	☐ 600/300			
Genvoya®	☐ 150/150/200/10			
Odefsey®	☐ 200/25/25			
Stribild™	☐ 150/150/200/300			
Symfi Lo™	☐ 400/300/300			
Trizivir®	☐ 300/150/300			
Truvada®	☐ 300/200			
NNRTIs				
Edurant™	☐ 25mg			
Intelence®	☐ 100mg			
Sustiva®	☐ 600mg			
Viramune XR®	☐ 400mg			
OTHER: ______________				

Medication	Dose	Directions	Qty	Refills
NRTIs				
Emtriva®	☐ 200mg			
Epivir®	☐ 150mg ☐ 300mg			
Retrovir®	☐ 300mg			
Viread®	☐ 300mg			
Ziagen®	☐ 300mg			
Integrase Inhibitors				
Isentress®	☐			
Tivicay®	☐			
Fusion Inhibitors				
Fuzeon®	☐ 90mg Vial			
Selzentry®	☐ 150mg ☐ 300mg			
Protease Inhibitors				
Norvir®	☐ 100mg			
Prezista®	☐ 600mg ☐ 800mg			
Reyataz®	☐ 100mg ☐ 150mg ☐ 200mg ☐ 300mg			
Other Medications				
Bactrim®	☐ S/S ☐ D/S			
Diflucan®	☐ 100mg ☐ 200mg			
Procrit®				

Please deliver to: ☐ Patient ☐ Office ☐ Other __________ by this 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: ______________________

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