HIV ENROLLMENT FORM

LifeCare
Specialty Pharmacy
Phone: 702-697-2105
Fax: 702-697-2107

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

Prior Authorization Reference Number: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ City, State, Zip: _____

Preferred Phone Number: _____ Alternate Phone: _____

Language Preference: ❑ English ❑ Spanish ❑ Other: _____ Weight: _____ lbs Height: _____

Concomitant Medications: _____

Allergies / Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____

Group / Hospital: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____ Phone Number: _____

DIAGNOSTIC / CLINCIAL INFORMATION – *Please fax recent clinical notes, Labs, Tests with the prescription to expedite the Prior Authorization*

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____

CD4 Count: _____ Viral Load: _____ Date of Labs: _____

PrEP: ❑ Yes ❑ No Hep B Test Completed? _____ ❑ Naive to Treatment Therapy

HLA-B*5701 Test Completed? _____ Hec C Test Completed? _____ ❑ Experienced to Reatment Therapy

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Qty	Refills
☐ Biktarvy	☐ 50/200/25 mg tablet			
☐ Atripla	☐ 600/200/300 mg tablet			
☐ Descovy	☐ 200/25 mg tablet			
☐ Dovato	☐ 50/300 mg tablet			
☐ Complera	☐ 200/25/300 mg tablet			
☐ Genvoya	☐ 150/150/200/10 mg tablet			
☐ Intelence	☐ 25 mg tablet ☐ 100 mg tablet ☐ 200 mg tablet			
☐ Isentress	☐ 25 mg chewable tablet ☐ 100 mg chewable tablet ☐ 100 mg granuales for suspension ☐ 400 mg tablet			
☐ Isentress HD	☐ 600 mg tablet			
☐ Juluca	☐ 50/25 mg tablet			
☐ Norvir	☐ 100 mg tablet ☐ 100 mg powder ☐ 80 mg/mL solution			

Medication	Dose / Strength	Directions	Qty	Refills
☐ Odefsey	☐ 200/25/25 mg tablet			
☐ Prezcobix	☐ 800/150 mg tablet			
☐ Prezista	☐ 75 mg tablet ☐ 150 mg tablet ☐ 600 mg tablet ☐ 800 mg tablet ☐ 100 mg/mL suspension			
☐ Stribild	☐ 150/150/200/300 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			
☐ Truvada	☐ 100/150 mg capsule ☐ 133/200 mg capsule ☐ 167/250 mg capsule ☐ 200/300 mg oral powder			
☐				
☐				
☐				
☐				

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, included the receipt of any required prior authorization forms the receipt and submission of patient label values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prespcription, 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: _____ Supervising Physician Signature: _____ Date: _____

Electronic or digital signatures not accepted.