HIV Enrollment Form

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ B20 Human Immunodeficiency Virus (HIV)

❑ Other: _____

New to current treatment: ❑ Yes ❑ No

Has the patient been tested for:

Hep B: ❑ Yes ❑ No

Hep C: ❑ Yes ❑ No

Test result: _____

CD4 count: _____

Date of lab: _____

HIV RNA: _____

Date of lab: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
NRTIs:				
❑ Cimduo®	❑ 300/300 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
❑ Combivir®	❑ 150/300 mg tablet	❑ Take one tablet by mouth twice daily. ❑ Other: _____		
❑ Descovy®	❑ 200/25 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
❑ Emtriva®	❑ 200 mg capsule	❑ Take one capsule by mouth once daily. ❑ Other: _____		
	❑ 10 mg/mL solution	❑ Take 240 mg (24 mL) by mouth once daily. ❑ Other: _____		
❑ Epivir®	❑ 150 mg tablet ❑ 300 mg tablet ❑ 10 mg/mL solution	❑ Take 150 mg by mouth twice daily. ❑ Take 300 mg by mouth once daily. ❑ Other: _____		
❑ Epzicom®	❑ 600/300 mg tablet	❑ Take one tablet by mouth once daily. ❑ Other: _____		
❑ Retrovir®	❑ 100 mg capsule ❑ 50mg/5 mL syrup	❑ Take _____ mg by mouth _____ time(s) daily. ❑ Other: _____		
❑ Trizivir®	❑ 300/150/300 mg tablet	❑ Take one tablet by mouth twice daily. ❑ Other: _____		
❑ Truvada®	❑ 100/150 mg tablet ❑ 133/200 mg tablet ❑ 167/250 mg tablet ❑ 200/300 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		

Deliver 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

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

HIV Enrollment Form

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ B20 Human Immunodeficiency Virus (HIV)

❑ Other: _____

New to current treatment: ❑ Yes ❑ No

Has the patient been tested for:

Hep B: ❑ Yes ❑ No

Hep C: ❑ Yes ❑ No

Test result: _____

CD4 count: _____

Date of lab: _____

HIV RNA: _____

Date of lab: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Videx EC®	❑ 125 mg capsule ❑ 200 mg capsule ❑ 250 mg capsule ❑ 400 mg capsule	❑ Take one capsule by mouth once daily on an empty stomach. ❑ Other: _____		
❑ Viread®	❑ 150 mg tablet ❑ 200 mg tablet ❑ 250 mg tablet ❑ 300 mg tablet ❑ 40 mg/1 g powder	❑ Take one tablet by mouth once daily. ❑ Other: _____		
❑ Zerit®	❑ 15 mg capsule ❑ 20 mg capsule ❑ 30 mg capsule ❑ 40 mg capsule ❑ 1 mg/mL solution	❑ Take _____ mg by mouth every 12 hours. ❑ Other: _____		
❑ Ziagen®	❑ 300 mg tablet	❑ Take 300 mg by mouth twice daily. ❑ Take 600 mg by mouth once daily. ❑ Other: _____		
❑ Zidovudine	❑ 100 mg capsule ❑ 300 mg tablet ❑ 50 mg/5 mL syrup	❑ Take 300 mg by mouth twice daily. ❑ Take 200 mg by mouth three times daily. ❑ Other: _____		
NNRTIs:				
❑ Edurant®	❑ 25 mg tablet	❑ Take one tablet by mouth once daily with a meal. ❑ Other: _____		
❑ Intelence®	❑ 25 mg tablet ❑ 100 mg tablet ❑ 200 mg tablet	❑ Take 200 mg by mouth twice daily following a meal. ❑ Other: _____		

Deliver 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

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

HIV Enrollment Form

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ B20 Human Immunodeficiency Virus (HIV)

❑ Other: _____

New to current treatment: ❑ Yes ❑ No

Has the patient been tested for:

Hep B: ❑ Yes ❑ No

Hep C: ❑ Yes ❑ No

Test result: _____

CD4 count: _____

Date of lab: _____

HIV RNA: _____

Date of lab: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Pifeltro™	❑ 100 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
❑ Sustiva®	❑ 50 mg capsule ❑ 200 mg capsule ❑ 600 mg tablet	❑ Take _____ mg by mouth once daily on an empty stomach. ❑ Other: _____		
❑ Viramune XR®	❑ 100 mg tablet ❑ 400 mg tablet	❑ Take _____ mg by mouth once daily. ❑ Other: _____		
Single Tablet Regimens:				
❑ Atripla®	❑ 600/200/300 mg tablet	❑ Take one tablet by mouth once daily on an empty stomach, preferably at bedtime. ❑ Other: _____		
❑ Biktarvy®	❑ 50/200/25 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
❑ Complera®	❑ 200/25/300 mg tablet	❑ Take one tablet by mouth once daily with food. ❑ Other: _____		
❑ Delstrigo™	❑ 100/300/300 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
❑ Genvoya®	❑ 150/150/200/10 mg tablet	❑ Take one tablet by mouth once daily with food. ❑ Other: _____		
❑ Juluca®	❑ 50/25 mg tablet	❑ Take one tablet by mouth once daily with a meal. ❑ Other: _____		
❑ Odefsey®	❑ 200/25/25 mg tablet	❑ Take one tablet by mouth once daily with a meal. ❑ Other: _____		
❑ Stribild®	❑ 150/150/200/300 mg tablet	❑ Take one tablet by mouth once daily with a meal. ❑ Other: _____		

Deliver 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

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

HIV Enrollment Form

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ B20 Human Immunodeficiency Virus (HIV)

❑ Other: _____

New to current treatment: ❑ Yes ❑ No

Has the patient been tested for:

Hep B: ❑ Yes ❑ No

Hep C: ❑ Yes ❑ No

Test result: _____

CD4 count: _____

Date of lab: _____

HIV RNA: _____

Date of lab: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Symfi™	❑ 600/300/300 mg tablet	❑ Take one tablet by mouth once daily on an empty stomach, preferably at bedtime. ❑ Other: _____		
❑ Symfi Lo™	❑ 400/300/300 mg tablet	❑ Take one tablet by mouth once daily on an empty stomach, preferably at bedtime. ❑ Other: _____		
❑ Symtuza®	❑ 800/150/200/10 mg tablet	❑ Take one tablet by mouth once daily with food. ❑ Other: _____		
❑ Triumeq®	❑ 600/50/300 mg tablet	❑ Take one tablet by mouth once daily, with or without food. ❑ Other: _____		
Integrase Inhibitors:				
❑ Isentress®	❑ 400 mg tablet	❑ Take one tablet (400 mg) by mouth twice daily. ❑ Other: _____		
❑ Isentress HD®	❑ 600 mg tablet	❑ Take 2 tablets (1200 mg) by mouth once daily. ❑ Other: _____		
❑ Tivicay®	❑ 10 mg tablet ❑ 25 mg tablet ❑ 50 mg tablet	❑ Take one tablet (50 mg) by mouth ❑ once ❑ twice daily. ❑ Other: _____		
Protease Inhibitors:				
❑ Evotaz®	❑ 300/150 mg tablet	❑ Take one tablet by mouth once daily with food. ❑ Other: _____		
❑ Kaletra®	❑ 200/50 mg tablet ❑ 100/25 mg tablet	❑ Take _____ tablets by mouth _____ daily. ❑ Other: _____		
❑ Lexiva®	❑ 700 mg tablet	❑ Take two tablets (1,400 mg) by mouth once daily with _____mg ritonavir once daily. ❑ Other: _____ *(Note: Please also select ritonavir on form)*		

Deliver 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

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

HIV Enrollment Form

PYRAMIDS PHARMACY WEBSTER

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ B20 Human Immunodeficiency Virus (HIV)

❑ Other: _____

New to current treatment: ❑ Yes ❑ No

Has the patient been tested for:

Hep B: ❑ Yes ❑ No

Hep C: ❑ Yes ❑ No

Test result: _____

CD4 count: _____

Date of lab: _____

HIV RNA: _____

Date of lab: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Prezcobix®	❑ 800/150 mg tablet	❑ Take one tablet by mouth once daily with food. ❑ Other: _____		
❑ Prezista®	❑ 75 mg tablet ❑ 150 mg tablet ❑ 600 mg tablet ❑ 800 mg tablet	❑ Take _____ mg by mouth with 100 mg ritonavir _____ daily with food. ❑ Take _____ mg by mouth with 150 mg cobicistat _____ daily with food. ❑ Other: _____ *(Note: Please also select ritonavir or cobicistat on form)*		
❑ Reyataz®	❑ 150 mg capsule ❑ 200 mg capsule ❑ 300 mg capsule	❑ Take 300 mg by mouth with 100 mg ritonavir once daily with food.. ❑ Take 300 mg by mouth with 150 mg cobicistat once daily with food.. ❑ Other: _____ *(Note: Please also select ritonavir or cobicistat on form)*		
❑ Viracept®	❑ 250 mg tablet ❑ 625 mg tablet	❑ Take 1250 mg by mouth twice daily with a meal. ❑ Take 750 mg by mouth three times daily with a meal. ❑ Other: _____		
Pharmacokinetic Enhancers:				
❑ Norvir®	❑ 100 mg tablet	_____		
❑ Tybost®	❑ 150 mg tablet	_____		
Entry Inhibitors:				
❑ Fuzeon®	❑ 90 mg Vial Kit	❑ Inject 90 mg (1 mL) subQ twice daily. ❑ Other: _____		
❑ Selzentry®	❑ 25 mg tablet ❑ 75 mg tablet ❑ 150 mg tablet ❑ 300 mg tablet ❑ 20mg/mL solution	❑ Take _____ mg by mouth twice daily, with or without food. ❑ Other: _____		

Deliver 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

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____