PYRAMIDS SPECIALTY PHARMACY

HIV Enrollment Form

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I 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: ____________

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