



HIV Enrollment Form

www.pyramidsparmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 | Pearland, TX 77584 | Phone: 1.888.375.1920 | 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
<input type="checkbox"/> Pifeltro™	<input type="checkbox"/> 100 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Sustiva®	<input type="checkbox"/> 50 mg capsule <input type="checkbox"/> 200 mg capsule <input type="checkbox"/> 600 mg tablet	<input type="checkbox"/> Take _____ mg by mouth once daily on an empty stomach. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Viramune XR®	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 400 mg tablet	<input type="checkbox"/> Take _____ mg by mouth once daily. <input type="checkbox"/> Other: _____		

Single Tablet Regimens:

<input type="checkbox"/> Atripla®	<input type="checkbox"/> 600/200/300 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily on an empty stomach, preferably at bedtime. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Biktarvy®	<input type="checkbox"/> 50/200/25 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Complera®	<input type="checkbox"/> 200/25/300 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with food. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Delstrigo™	<input type="checkbox"/> 100/300/300 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Genvoya®	<input type="checkbox"/> 150/150/200/10 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with food. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Juluca®	<input type="checkbox"/> 50/25 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with a meal. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Odefsey®	<input type="checkbox"/> 200/25/25 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with a meal. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Stribild®	<input type="checkbox"/> 150/150/200/300 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily with a meal. <input type="checkbox"/> 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: _____