HIV Enrollment Form

PYRAMIDS SPECIALTY PHARMACY

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
☐ 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:				
☐ Dovato®	☐ 50/300 mg tablet	☐ Take one tablet by mouth once daily		
☐ 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: _____