HIV Enrollment Form



Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

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PRESCRIBER INFORMATION					
escriber's Name:	State	e License #:	NPI #:	DEA #:	
oup or Hospital:					
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one: Fax	Cont	act Person:		Contact's Phone:	
NSURANCE INFORMATION P	lease fax copy of prescription	on and insurance card	ls with this form, if	available (front and	back)
DIAGNOSIS AND CLINICAL IN	FORMATION				
eds by Date: Ship to:	Patient Office Other:	:			
agnosis (ICD-10):					
B18.0 Chronic Viral Hepatitis B with	Delta Agent B18.1 C	hronic Viral Hepatitis E	3 without Delta-Ac	gent	
B18.2 Chronic Viral Hepatitis C	·	ıman Immunodeficien	•	•	
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Other Code: Description		- (-	, , ,		
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

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escriber Name:							Prescriber Phone:			
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MEDICATION			STRENGTH			DOS	SE & DIRECTIONS	QUANT	ITY/REFILLS	
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Combivir] 150/30	0/300 mg			Ot	her:		Quantity:	Refills:	
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Intelence Pifeltro	25 100	mg _ Omg tab	olet			Other: Take onc	ce daily with or without food	Quantity: Quantity: Quantity:	Refills: Refills: Refills:	
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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HIV Enrollment Form

	Please Con	nplete Patient a	and Prescriber Informat	ion		
Patient Name:	Patient DOB:					
Prescriber Name:		ne:				
5 PRESCRIPTIO	N INFORMATION					
Protease Inhibitors:	<u>-</u>					
MEDICATION	STRENG	тн	DOSE & DIRECTI		TY/REFILLS	
Aptivus	250 mg 100 mg/mL		Other:	Quantity:	Refills:	
Crixivan	200 mg 400 mg		Other:	Quantity:	Refills:	
Evotaz	300/150 mg		Other:	Quantity:	Refills:	
☐ Invirase	☐ 200 mg ☐ 500 mg		Other:	Quantity:	Refills:	
Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL		Other:	Quantity:	Refills:	
Lexiva	☐ 700 mg		Other:	Quantity:	Refills:	
Norvir	☐ 100 mg ☐ 80 mg/mL		Other:	Quantity:	Refills:	
Prezcobix	800/150 mg		Other:	Quantity:	Refills:	
Prezista	75 mg 150 mg 600	mg 🗌 800 mg	Other:	Quantity:	Refills:	
Reyataz	☐ 150 mg ☐ 200 mg ☐ 300		Other:	Quantity:	Refills:	
Viracept	250 mg 625 mg	···9	Other:	Quantity:	Refills:	
Entry Inhibitors:						
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANT	ITY/REFILLS	
Fuzeon	90 mg vial	Other:		Quantity:		
Selzentry	☐ 150 mg ☐ 300 mg	Other:		Quantity:		
Pharmacokinetic Er						
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTI	ITY/REFILLS	
Tybost	☐ 150 mg	Other:		Quantity:	Refills:	
Miscellaneous:						
MEDICATION	STRENGTH		DOSE & DIRECTIONS		ITY/REFILLS	
Bactrim	Other:	Other:		Quantity:	Refills:	
Diflucan	Other:	Other:		Quantity:	Refills:	
Egrifta SV	NA		ust be sent through the HUE 844-EGRIFTA or 1-844-347-43 8069	- I () antit\/:()		
Mytesi	125 mg tablet	Take twice d	aily with or without food	Quantity:	Refills:	
Rukobia	600 mg Extended-Release	Other:		Quantity:	Refills:	
Serostim	Other:	Other:		Quantity:	Refills:	
Trogarzo	NA NA	All referrals mu	st be sent through the HUB, (833)-238-4372 Fax 1-(855)-83	Trogarzo Quantity: 0	•	
Other:			•			
MEDICATION		NGTH	DOSE & DIRECTION		ITY/REFILLS	
Other:	Other:		Other:	Quantity:	Refills:	
Other:	Other:		Other:	Quantity:	Refills:	
	patient support programs PRESCRIBER SIGNATU	STAMP SIGNATURE	ŕ	supplies and kits provided as need E NOT ALLOWED)		
DAW / May Not Substi		titute / No Substitution / May Substitute / Product Selection F Substitution Permissible		lection Permitted /		
Prescriber's Signature:		Date:	Prescriber's Signatu	re:	Date:	
	erchange is mandated unless Prescriber writes		n" ATTN: New Yo	ork and Iowa providers, please	submit electronic prescri	
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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