ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

HIV ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address:

Phone: Alternate Phone:

Height: Weight: Insurance Information: ☐ Attached

Allergies:

DIAGNOSIS

Diagnosis (ICD-10): ☐ B20 HIV ☐ B18.0 HBV with delta agent (Chronic) ☐ B18.2 HCV (Chronic) ☐ Other code: _____ Description: _____

☐ Treatment Naive ☐ Prior Regimen (Most recent): _____ ☐ Prior Duration: _____ ☐ Reason for switching drug: _____

CD4: _____(date)_____ Viral Load Result: ☐ Detected ☐ Undetected HIV RNA: _____ (date) _____ ☐ HLA-B 5701 Negative

DRUG

NRTIs		SIG	QTY	REFILLS
☐ Viread®	☐ 150mg ☐ 200mg ☐ 250mg ☐ 300mg			
☐ Ziagen®	☐ 300mg			
NNRTIs				
☐ Edurant®	☐ 25mg	Take 1 tablet by mouth daily with a meal		
COMBINATION ANTIRETROVIRALS				
☐ Atripla®	600/200/300	Take 1 tablet by mouth daily on an empty stomach		
☐ Biktarvy®	50/200/25	Take 1 tablet by mouth daily		
☐ Combivir®	150/300	Take 1 tablet by mouth twice daily		
☐ Complera®	200/25/300	Take 1 tablet by mouth daily with food		
☐ Delstrigo®	100/200/300	Take 1 tablet by mouth daily		
☐ Descovy®	200/25	Take 1 tablet by mouth daily		
☐ Epzicom®	600/300	Take 1 tablet by mouth daily		
☐ Genvoya®	150/150/200/10	Take 1 tablet by mouth daily with food		
☐ Juluca®	50/25	Take 1 tablet by mouth daily with food		
☐ Odefsey®	200/25/25	Take 1 tablet by mouth daily with food		
☐ Prezcobix	800/150	Take 1 tablet by mouth daily with food		
☐ Stribild®	150/150/200/300	Take 1 tablet by mouth daily with food		
☐ Symfi®	600/300/300	Take 1 tablet by mouth daily on an empty stomach		
☐ Symfi Lo®	400/300/300	Take 1 tablet by mouth daily on an empty stomach		
☐ Symtuza®	800/150/200/10	Take 1 tablet by mouth daily with food		
☐ Triumeq®	600/50/300	Take 1 tablet by mouth daily		
☐ Trizivir®	300/150/300	Take 1 tablet by mouth twice daily		
☐ Truvada®	200/300	Take 1 tablet by mouth daily		

PROTEASE INHIBITORS		SIG	QTY	REFILLS
☐ Kaletra®	☐ 200/50 ☐ 100/25			
☐ Norvir®	100mg			
☐ Prezista®	☐ 75mg ☐ 150mg ☐ 600mg ☐ 800mg			
☐ Reyataz®	☐ 150mg ☐ 200mg ☐ 300mg			
INTEGRASE INHIBITORS				
☐ Isentress®	400mg	Take 1 tablet by mouth twice daily		
☐ Tivicay®	50mg			
☐ Vitekta®	☐ 85mg ☐ 150mg			
OTHER				
☐ Tybost®	150mg			
PROVIDE PRESCRIPTIONS FOR NON-LISTED ANTIRETROVIRALS BELOW				
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☐ Ship order to patient, complete phone education ☐ Ship first order to the office for nurse visit/teach ☐ Ship all orders to office

PROVIDER SIGNATURE **DATE**

10.3.2016

PHYSICIAN NAME **DEA #:** **NPI #:** **STATE LICENSE #:**

PRACTICE NAME: **ADDRESS:** **CITY, STATE:** **ZIP:**

PHONE #: **FAX** **OFFICE CONTACT:**

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.