



# HIV ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION	Patient: _____ Caregiver: _____
	DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ Cell _____ Alternate Phone #: _____ Cell _____
	Allergies: _____

**PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION**

MEDICAL ASSESSMENT	<b>DIAGNOSIS:</b> 042 HIV/AIDS 079.53 HIV-2 070.32 HBV (Chronic) 070.54 HCV (Chronic) Other: _____
	New to current therapy Yes No CD4: _____ Date: _____ HIV RNA: _____ Date: _____

ANTIRETROVIRALS (ARVS)	MEDICATION	STRENGTH (mg)	DOSING	QTY	REFILLS
	Aptivus® (tipranavir) (TPV)	250	Two capsules BID (Q12 hours)	_____	_____
	Atripla® (EFV/FTC/TDF)	600/200/300	One tablet QD HS on an empty stomach	_____	_____
	Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide)	50/200/25	One tablet QD	_____	_____
	Cimduo (lamivudine/tenofovir disoproxil fumarate)	300/300	One tablet QD	_____	_____
	Combivir® (lamivudine/zidovudine)	150/300	One tablet BID (Q12 hours)	_____	_____
	Complera® (FTC/rilpivirine/TDF)	200/25/300	One tablet QD with food	_____	_____
	Crixivan® (indinavir) (IDV)	400	_____	_____	_____
	Delstrigo (doravirine/lamivudine/tenofovir disoproxil fumarate)	100/300/300	One tablet QD	_____	_____
	Descovy (emtricitabine/tenofovir alafenamide)	200/25	One tablet QD	_____	_____
	Dovato (dolutegravir/lamivudine)	50/300	One tablet QD	_____	_____
	Edurant® (rilpivirine) (RPV)	25	One tablet QD with a meal	_____	_____
	Emtriva® (emtricitabine) (FTC)	200	One capsule QD	_____	_____
	Epivir® (lamivudine) (3TC)	_____	_____	_____	_____
	Epzicom® (abacavir/lamivudine) (ABC/3TC)	600/300	One tablet QD	_____	_____
	Evotaz® (atazanavir/cobicistat)	300/150	One tablet QD with food	_____	_____
	Fuzeon® (enfuvirtide)	90	90 mg (1mL) Sub-Q BID (Q12 hours)	_____	_____
	Genvoya (cobicistat/evitegravir/emtricitabine/tenofovir alafenamide)	150/150/200/10	One tablet QD with food	_____	_____
	Intelence® (etravirine) (ENF)	_____	_____	_____	_____
	Invirase® (saquinavir) (SQV)	_____	_____	_____	_____
	Isentress® (raltegravir) (RAL)	400	One tablet BID (Q12 hours)	_____	_____
	Isentress HD (raltegravir)	600	Two tablets once daily	_____	_____
	Juluca (dolutegravir/rilpivirine)	50/25	One tablet QD with a meal	_____	_____
	Kaletra® (lopinavir/ritonavir)	200/50	_____	_____	_____
	Lexiva® (fosamprenavir) (FPV)	700	_____	_____	_____
	Norvir® (ritonavir) tablets (RTV)	100	_____	_____	_____
	Odefsey (emtricitabine/rilpivirine/tenofovir alafenamide)	200/25/25	One tablet QD with a meal	_____	_____
	Pifeltro (doravirine)	100	One tablet QD	_____	_____
	Prezcobix® (darunavir/cobicistat)	800/150	One table QD with food	_____	_____
	Prezista® (darunavir) (DRV)	75 or 150 or 600 or 800 or 100mg/mL	_____	_____	_____
	Retrovir® (zidovudine) (ZDV)	_____	_____	_____	_____
	Reyataz® (atazanavir) (ATV)	_____	_____	_____	_____
	Rukobia (fostemsavir)	600	One tablet BID	_____	_____
	Selzentry® (maraviroc) (MVC)	150 or 300	_____	_____	_____
	Stribild™ (EVG/COBI/FTC/TDF)	150/150/200/300	One tablet QD with food	_____	_____
	Sustiva® (efavirenz) (EFV)	_____	_____	_____	_____
	Symfi (efavirenz/lamivudine/tenofovir disoproxil fumarate)	600/300/300	One tablet QD HS on an empty stomach	_____	_____
	Symfi Lo (efavirenz/lamivudine/tenofovir disoproxil fumarate)	400/300/300	One tablet QD HS on an empty stomach	_____	_____



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	MEDICATION	STRENGTH (mg)	DOSING	QTY	REFILLS
<b>ANTIRETROVIRALS (ARVS)</b>	Symtuza (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	800/150/200/10	One tablet QD with food	_____	_____
	Tivicay® (dolutegravir) (DTG)	_____	_____	_____	_____
	Triumeq® (abacavir/dolutegravir/lamivudine)	600/50/300	One tablet daily	_____	_____
	Trizivir (ABC/3TC/ZDV)	300/150/300	One tablet BID (Q12 hours)	_____	_____
	Truvada® (emtricitabine/tenofovir)	200/300	One tablet QD	_____	_____
	Tybost (cobicistat)	150	One tablet QD with food	_____	_____
	Viracept® (nelfinavir) (NFV)	250 or 625	_____	_____	_____
	Viramune® (nevirapine) (NVP)	200	_____	_____	_____
	Viramune® XR™ (nevirapine ER) (NVP)	400	One tablet QD	_____	_____
	Viread® (tenofovir) (TDF)	300	One tablet QD	_____	_____
	Vitekta® (elvitegravir)	85 or 150	_____	_____	_____
	Zerit® (stavudine) (D4T)	_____	_____	_____	_____
	Ziagen® (abacavir) (ABC)	300	One tablet BID or two tablets daily	_____	_____

	INJECTION TRAINING:	OFFICE TO COORDINATE	HEALTHDYNE SPECIALTY TO COORDINATE
<b>PRESCRIBER INFORMATION</b>	Anticipated Start Date: _____ Prescriber Specialty: _____		
	Ship to: Patient Physician Clinic Other: _____		
	Fax #: _____ Contact Name: _____		
	Office Address: _____ City: _____ State: _____ Zip: _____		
	The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.		
	I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.		
Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____			
Use substitution Dispense as written			

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