HEALTH EXPRESS PHARMACIES SPECIALTY CARE

HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: **888-453-1203** • Fax: **844-786-9706**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

ICD-10: _____ Date of Diagnosis: _____ Contraindications: ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
1. CD/4/T-cell	_____	_____
2. HIV RNA	_____	_____
3. Viral Load	_____	_____
4. Liver Biopsy	_____	_____

Blood Results:

Date Drawn _____ Hgb/Hct: _____ WBC: _____

If Prior Authorization is Denied:

❑ Automatically Draft Appeal for Review

❑ Send Preferred Formulary Alternatives

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication				Dosage & Strength/Directions	QTY	Refills
NRTIs/NNRTIs						
❑ **DESCOVY®** 200/25mg	❑ **INTELENCE®**	❑ **VIDEX®**	❑ **ZERIT®**			
❑ **EDURANT®** 25mg	❑ **RESCRIPTOR®**	❑ **VIRAMUNE®**	❑ **ZIAGEN®**			
❑ **EMTRIVA®**	❑ **RETROVIR®**	❑ **VIRAMUNE XR®**				
❑ **EPIVIR®**	❑ **SUSTIVA®**	❑ **VIREAD®**				
Protease Inhibitors						
❑ **APTIVUS®** 250mg	❑ **INVIRASE®**	❑ **PREZISTA®**				
❑ **CRIXIVAN®**	❑ **KALETRA®** 200/50mg	❑ **REYATAZ®**		❑ _____		
❑ **EVOTAZ™** 300/150mg	❑ **LEXIVA®**	❑ **VIRACEPT®**				
❑ **NORVIR®** 100mg Capsules	❑ **NORVIR®** 100mg Tablets			❑ Take 2, twice daily (❑ Capsules ❑ Tablets)		
Combinations						
❑ **ATRIPLA®** 600/200/300mg	❑ **GENVOYA®** 150/150/200/10mg	❑ **STRIBILD®** 150/150/200/300mg		❑ Take 1 tablet, once daily ❑ Take 1 tablet, twice daily ❑ Take 1 tablet, with a meal daily ❑ _____		
❑ **COMBIVIR®** 150/300mg	❑ **JULUCA®** 50/25mg	❑ **TRIUMEQ®** 600/50/300mg				
❑ **COMPLERA®** 200/25/300mg	❑ **ODEFSEY®** 200/25/25mg	❑ **TRIZIVIR®** 300/150/300mg				
❑ **EPZICOM®** 600/300mg	❑ **PREZCOBIX®** 800/150mg	❑ **TRUVADA®** 200/300mg				
Integrase Inhibitor/CCR5 I						
❑ **ISENTRESS®** 400mg	❑ **SELZENTRY®**	❑ **TIVICAY®** 50mg	❑ **VITEKTA®**	❑ Take 1 tablet, twice daily ❑ _____		
Supportive Medications						
❑ Acyclovir	❑ Dapsone	❑ Tybost®	❑ Other			
❑ Bactrim® (TMC/SMZ)	❑ Diflucan®	❑ Valtrex®				
❑ Bactrim® DS(TMP/SMZ)	❑ Fuzeon®	❑ Zithromax®				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.