HIV ENROLLMENT FORM

Connection • Care • Community

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name ______
Address ______
Apt/Suite ______ City ______
State ______ Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ SSN ______ Gender ○ M ○ F
Weight ______ kg/lbs Height ______ cm/in
Language Preference: ○ English ○ Spanish ○ Other ______

Prescriber Information

Prescriber's Name ______
NPI ______ DEA ______
Address ______
Apt/Suite ______ City ______
State ______ Zip ______
Contact ______
Phone ______ Alternate Phone ______
Fax ______
Prescriber's Name ______
NPI ______ Office Contact ______

Medical Information (Section must be completed to process prescription) Attach separate sheet if needed

Diagnosis — Please include diagnosis name with ICD-10 code

ICD-10
- ○ B18.1 Chronic viral hepatitis B w/o delta-agent
- ○ R64 Cachexia
- ○ B18.2 Chronic viral hepatitis C
- ○ B20 Human immunodeficiency virus [HIV]
- ○ Other ______

Date of diagnosis ______

Patient Evaluation

Allergies / Comments ______
Concomitant Medications ______
Weight ______ kg / lbs Height ______ cm / in BMI ______
○ Naïve to Treatment Therapy ○ Experienced to Treatment Therapy

Lab Data	Lab Value	Baseline	Current
CD4 / T-cell Count			
HIV RNA			
Hgb/Hct			
White Blood cell count			
Creatinine Clearance			

Prescription Information

Drugs	Direction	Quantity	Refills
NRTIs			
○ Emtriva®	○ 200mg ______		
○ Epivir®	○ 150mg ○ 300mg ○ ______		
○ Retrovir®	○ 300mg ______		
○ Videx EC®	○ 125mg ○ 300mg ○ 250mg ○ 400mg ______		
○ Viread®	○ 300mg ______		
○ Zerit®	○ 20mg ○ 30mg ○ 40mg ______		
○ Ziagen®	______		
NNRTIs			
○ Edurant™	○ 25mg ______		
○ Intelence®	○ 100mg ______		
○ Sustiva®	○ 600mg ______		
○ Viramune XR®	○ ______		
Entry Inhibitors			
○ Fuzeon®	○ 90mg vial ______		
○ Selzentry®	○ 150mg ○ 300mg ______		
Integrase Inhibitors			
○ Isentress®	○ ______		
○ Tivicay®	○ 50mg ______		

Drugs	Direction	Quantity	Refills
Combination Antiretrovirals			
○ Atripla®	○ 300 / 200 / 600 ______		
○ Combivir®	○ 300 / 150 ______		
○ Complera®	○ 300 / 200 / 25 ______		
○ Epzicom®	○ 600 / 300 ______		
○ Odefsy	○ 200 / 25 / 25 ______		
○ Stribild™	○ 150 / 150 / 200 / 300 ______		
○ Trizivir®	○ 300 / 150 / 300 ______		
○ Truvada®	○ 300 / 200 ______		
○ Genvoya®	○ 150/150/200/10 ______		
○ Triumeq®	○ 600/50/300 ______		
Protease Inhibitors			
○ Aptivus®	○ 250mg ______		
○ Crixivan®	○ 400mg ______		
○ Invirase®	○ 500mg ______		
○ Kaletra®	○ 200 / 50 ______		
○ Lexiva®	○ 700mg ______		
○ Norvir®	○ 100mg ______		
○ Prezista®	○ 600mg ○ 800mg ______		
○ Reyataz®	○ 100mg ○ 150mg ○ 200mg ○ 300mg ______		
○ Viracept®	○ 250mg ○ 625mg ______		
Other Medications			
○ Bactrim®	○ S / S ○ D / S ______		
○ Diflucan®	○ 100mg ○ 200mg ______		

Ship 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.

Prescriber's Signature: ______ ______ ***Date:*** ______
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: ______

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

GREENHILL PLUS
Specialty Pharmacy Solution
Connection • Care • Community
Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR PATIENTS WITH HIV/AIDS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward to us any updates you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ○ Patient name
- ○ Patient Demographics (Address, Phone Number, DOB, etc.)
- ○ Medication list and allergies
- ○ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ○ MD name/NPI/Office contact/Phone number
- ○ Drug indicated with refills
- ○ MD signature and date on referral form
- ○ CD4 count
- ○ Is the patient co-infected HIV/Hep C?
- ○ Previous therapy

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