AccuSERV® PHARMACY

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

HIV Prescription Enrollment Form

Fax: (877) 526-8823 Pharmacy Phone: (866) 213-9821

1. Patient Information

Start Date:___________ **Ship to:** ___ Patient ___ Office __________ Other

Patient Name: ____________________________________ M / F DOB:______________ SSN:_______________

Address: ____Phone #:_________________

Caregiver:____________________ Allergies: __________________________ Alt Phone #:_________________

Comorbidities: ____ Height: __________ Weight: _________

2. Clinical Information *please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:______________________ Prior Therapy: _____________________________________

New to current therapy? Yes / No CD4:_________ Date:________ HIV RNA:____________ Date:_________

3. Prescription Information *if your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

Please fax a list of patient's other medications and choose packaging:_____ *AccuPAC®*____ Bottles ____ Check to learn more about *AccuPAC®*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Aptivus®	__ 250 mg ___ (with Norvir®)	__ Take 2 caps by mouth 2x a day (Q12H)	_____gel cap	
	Atripla®	__ 600/200/300 mg	__ Take 1 tab by mouth every day (empty stomach)	_______ tabs	
	Combivir®	__ 150/300 mg	__ Take 1 tab by mouth 2x a day (Q12H)	_______ tabs	
	Complera®	__ 200/25/300 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Crixivan®	__ 400 mg	__ Take 1 cap by mouth every day w/food	______ caps	
	Edurant®	__ 25 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Emtriva®	__ 200 mg	__ Take 1 cap by mouth every day	______ caps	
		__ 10 mg/ mL oral solution	__ Take 24 mL every day	__ 170 mL	
	Epivir®	__ 150 mg __ 300 mg	__ Take _____ tabs ____ times per day	_______ tabs	
	Epzicom®	__ 600/300 mg	__ Take 1 tab by mouth every day	_______ tabs	
	Evotaz®	__ 300/150 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Fuzeon®	__ 90 mg injection	__ Inject 1mL Sub-Q 2x a day (Q12H)	__ 60(1mL)vials	
	Genvoya®	__ 150/150/200/10 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Intelence®	__ 100 mg __ 200 mg	__ Take _____ tabs 2x a day, following a meal	_______ tabs	
	Invirase®	__ 500 mg	__ Take _____ tabs ____ times per day	_______ tabs	
	Isentress®	__ 100 mg chewable __ 100 mg pkt __ 400 mg tab __ 600 mg tab	__ Take _____ mg by mouth every day __	_______ tabs ___ 60 pkts	
	Kaletra®	__ 100/25 mg __ 200/50 mg __ 400/100 mg/5 mL	__ Take _____ tabs ____ times per day __ Take _____ mL ____ times per day	_______ tabs ________ mL	
	Lexiva®	__ 700 mg __ 50 mg/mL oral suspension	__ Take _____ tabs ____ times per day __ Take _____ mL ____ times per day	_______ tabs ________ mL	
	Mepron®	__ 750 mg/5mL	__ Take _____ mL ____ times per day	________ mL	
	Norvir®	__ 100 mg __ 80 mg/mL solution	__ Take _____ tabs ____ times per day __ Take _____ mL ____ times per day	_______ tabs ___ 240 mL	

	Odefsey®	__ 200/25/25 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Prezcobix®	__ 800/150 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Prezista®	__ 600 mg __ 800 mg	__ Take _____ tabs ____ times per day w/food	_______ tabs	
	Rescriptor®	__ 200 mg	__ Take 2 tabs by mouth 3x a day	_______ tabs	
	Retrovir®	__ 100 mg __ 50 mg/5mL syrup	__ Take _____ mg by mouth ____ times per day __ Take _____ mL by mouth ____ times per day	______ caps ________ mL	
	Reyataz®	__ 150 mg __ 200 mg __ 300 mg __ 50 mg pkt	__ Take _____ mg by mouth ____ times per day	______ caps ______ pkts	
	Selzentry®	__ 25 mg __ 75 mg __ 150 mg __ 300 mg __ 20 mg/mL solution	__ Take _____ mg by mouth ____ times per day __ Take _____ mL ___ times per day	_______ tabs ________ mL	
	Stribild®	__ 150/150/200/300 mg	__ Take 1 tab by mouth every day w/food	_______ tabs	
	Sustiva®	__ 50 mg cap __ 200 mg cap __ 600mg tab	__ Take _____ mg by mouth at bedtime	_______ tabs ______ caps	
	Tivicay®	__ 50 mg	__ Take 1 tab by mouth ____ times per day	_______ tabs	
	Trizivir®	__ 300/150/300 mg	__ Take 1 tab by mouth 2x a day (Q12H)	_______ tabs	
	Triumeq®	__ 600/50/300 mg	__ Take 1 tab by mouth every day	_______ tabs	
	Truvada®	__ 100/150 mg __ 200/300 mg	__ Take 1 tab by mouth every day	_______ tabs	
	Tybost®	__ 150 mg	__ Take 1 tab by mouth every day	_______ tabs	
	Videx® EC	__ 125 mg __ 200 mg __ 250 mg __ 400 mg	__ Take _____ mg by mouth ____ times per day	______ caps	
	Viracept®	__ 250 mg __ 625 mg	__ Take _____ mg by mouth ____ times per day	_______ tabs _______ tabs	
	Viramune®	__ 200 mg __ 50 mg / 5 mL Suspension	__ Take _____ mg by mouth ____ times per day __ Take _____ mL mouth every day	___ 60 tabs ___ 240 mL	
	Viramune XR®	__ 400 mg	__ Take 1 tab by mouth every day	___ 30 tabs	
	Viread®	__ 150 mg __ 200 mg __ 250 mg __ 300 mg __ 40 mg/scoop powder	__ Take _____ mg by mouth ____ times per day	___ 30 tabs ___ 60 grams	
	Zerit®	__ 15 mg __ 20 mg __ 30 mg __ 40 mg __ 1 mg/ mL oral solution	__ Take _____ mg by mouth ____ times per day __ Take _____ mL by mouth ____ times per day	______ caps ________ mL	
	Ziagen®	__ 300 mg __ 20mg / mL solution	__ Take _____ mg _____ times a day __ Take _____ mL by mouth _____ times per day	_______ tabs ________ mL	

4. Prescriber and Shipping Information

Preferred Method of Contact: __ phone __ fax __ email

Prescriber (print) : ______________________________ Office Contact: ________________

Phone: ______________ Contact email: ____________________ Fax: ______________

Office Address: ______________________________________ NPI: ______________

Prescriber's Signature: ______________________________ Date: ________ DEA: ________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.