SPS Specialty Pharmacy Services, Inc.

**Contact for Office:** 787-704-2025 /2028
**FAX:** 787-704-2027

# HIV ENROLLMENT

## Patient Info.

Patient SS#:_____ DOB:_____ ☐ Male ☐ Female Allergies: _____
Patient First Name:_____ Patient Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Caregiver:_____ ☐ NKDA

**INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)**

## Medical Info

Diagnosis: ☐ 042 HIV/AIDS ☐ 079.53 HIV-2 ☐ 070.32 HBV (Chronic) ☐ 070.54 HCV (Chronic)
New to current therapy ☐ Yes ☐ No CD4: _____ Date:_____ HIV RNA: _____ Date: _____ Weight: _____ kg/lbs

## Antiretrovirals (ARVs)

| Medication | Strength (mg) | Dosing | Qty | Refills |
|---|---|---|---|---|
| Aptivus® (tipranavir) | 250 | Two capsules by mouth BID (Q12 hours) | | |
| Atripla® (EFV/FTC/TDF) | 600/200/300 | One tablet by mouth QD on an empty stomach | | |
| Combivir® (lamivudine/zidovudine) | 150/300 | One tablet by mouth BID (Q12 hours) | | |
| Complera® (FTC/rilpivirine/TDF) | 200/25/300 | One tablet by mouth QD with food | | |
| Crixivan® (indinavir) | | | | |
| Edurant® (rilpivirine) | 25 | One tablet by mouth QD with a meal | | |
| Emtriva® (emtricitabine) | 200 | One capsule by mouth QD | | |
| Epivir® (lamivudine) | | | | |
| Epzicom® (abacavir/lamivudine) | 600/300 | One tablet by mouth QD | | |
| Fuzeon® (enfuvirtide) | 90 | 90 mg (1mL) Sub-Q BID (Q12 hours) | | |
| Intelence® (etravirine) | | | | |
| Invirase® (saquinavir) | | | | |
| Isentress® (raltegravir) | 400 | One tablet by mouth BID (Q12 hours) | | |
| Kaletra® (lopinavir/ritonavir) | 200/50 | | | |
| Lexiva® (fosamprenavir) | 700 | | | |
| Norvir® (ritonavir) capsules | 100 | | | |
| Norvir® (ritonavir) tablets | 100 | | | |
| Prezista® (darunavir) | | | | |
| Rescriptor® (delavirdine) | | | | |
| Retrovir® (zidovudine) | | | | |
| Reyataz® (atazanavir) | | | | |
| Selzentry® (maraviroc) | | | | |
| Stribild™ (EVG/COBI/FTC/TDF) | 150/150/200/300 | One tablet by mouth QD with food | | |
| Sustiva® (efavirenz) | | | | |
| Tivicay® (dolutegravir) | 50 | | | |
| Trizivir® (ABC/3TC/AZT) | 300/150/300 | One tablet by mouth BID (Q12 hours) | | |
| Truvada® (emtricitabine/tenofovir) | 200/300 | One tablet by mouth QD | | |
| Videx® EC (didanosine) | | | | |
| Viracept® (nelfinavir) | | | | |
| Viramune® (nevirapine) | 200 | | | |
| Viramune® XR™ (nevirapine ER) | 400 | One tablet by mouth QD | | |
| Viread® (tenofovir) | 300 | | | |
| Zerit® (stavudine) | | | | |
| Ziagen® (abacavir) | 300 | | | |

### Other Medications

☐ Acyclovir
☐ Bactrim® (TMP/SMZ)
☐ Bactrim® DS (TMP/SMZ)
☐ Dapsone
☐ Diflucan® (fluconazole)
☐ Serostim® (somatropin)
☐ Valtrex® (valacyclovir)
☐ Zithromax® (azithromycin)

Strength:_____
Directions: _____
_____
Qty: _____
Refills: _____

### Packaging

☐ Compliance Packaging
☐ Vials

## Prescriber Information

Ship to: ☐ Patient ☐ Physician/Clinic ☐ Other:_____
Physician Name: _____
Phone #: _____Fax #:_____ NPI #:_____ Contact Name: _____
Office Address: _____ City: _____ State:_____ Zip: _____
I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician's Signature:_____ Date:_____

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