HIV

Please fax to
855.291.7860

EntrustRx
Specialty Pharmacy With A Personal Touch
4284 New Getwell Road
Memphis, TN 38118
p 901.367.9484
tf855.394.2930

PATIENT INFORMATION

Last Name _____ First Name _____ Home Address _____
_____ City _____ State _____ Zip _____ Home Phone
_____ Work/Mobile Phone _____ E-mail _____
Social Security # _____ Date of Birth _____ Gender: ❑ Male ❑ Female
Primary Caregiver _____ Relation _____ Phone _____
Emergency Contact _____ Relation _____ Phone _____

INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

1. Primary Insurance _____ ID # _____ Group # _____ Phone _____
   Insured's Name _____ Insured's Employer _____ Relationship _____
2. Secondary Insurance _____ ID # _____ Group # _____ Phone _____
   Insured's Name _____ Insured's Employer _____ Relationship _____

CLINICAL INFORMATION

ICD-10 Code _____ Primary Diagnosis _____
Current Weight _____ kg/lbs Height _____ inches/cm BMI _____
Allergies: ❑ Yes ❑ No If yes, please list _____

❑ Naive to Treatment Therapy ❑ Experienced to Treatment Therapy ***please include most current lab results***

	MEDICATION NAME	STRENGTH	DOSAGE	QTY	REFILL
NRTIs					
	EMTRIVA®	200mg	one tablet taken orally once daily		
	EPIVIR®	150mg	[ ]150 mg twice daily / [ ] 300mg once daily		
	VIREAD®	300mg	one tablet taken orally once daily		
	ZIAGEN®	300mg	[ ] 300mg twice daily / [ ] 600mg once daily		
NNRTIs					
	EDURANT®	25mg	one tablet taken with a meal		
	INTELENCE®	[ ] 25mg / [ ] 100mg / [ ] 200mg	200 mg taken twice daily following a meal		
	SUSTIVA®	[ ] 50mg caps / [ ] 200mg caps / [ ] 600mg tabs			
	VIRAMUNE XR™	400mg			
Protease Inhibitors					
	INVIRASE®	[ ] 200mg cap / [ ] 500mg tab	1000 mg twice daily within 2 hours after a meal		
	LEXIVA®	700mg	Tablet taken orally twice daily		
	NORVIR®	100mg [ ] caps (*must refrigerate)* [ ] tabs	600mg twice daily with meals		
	PREZISTA®	[ ] 75mg / [ ] 150mg / [ ] 600mg / [ ] 800mg	_____ Mg taken orally once daily with food		
	REYATAZ®	[ ] 150mg / [ ] 200mg / [ ] 300mg	_____ Mg taken orally once daily with food		
Integrase Inhibitors					
	ISENTRESS®	400mg	one tablet taken orally twice daily		
	TIVICAY®	50mg	[ ] once daily / [ ] twice daily		
Combination					
	ATRIPLA®	600mg(EFV) /200mg(FTC)/300mg(TDF)	one tablet on an empty stomach at bedtime		
	COMPLERA®	200mg (FTC) / 25mg (RPV) / 300mg (TDF)	one tablet taken orally once daily with food		
	DESCOVY®	200MG (FTC)/ 25mg (TAF)	one tablet taken orally once daily		
	EPZICOM®	600mg (ABC) / 300mg(3TC)	one tablet taken orally once daily		
	GENVOYA®	150mg(EVG)/ (COBI)/ 200mg (FTC)/10 (TAF)	one tablet taken orally once daily with food		
	KALETRA®	200mg(LPV)/ 50mg(R)	[ ] two tabs twice daily / [ ] three tabs twice daily		
	STRIBILD®	150mg(EVG)/ (COBI)/ 200mg(FTC)/300mg(TDF)	one tablet taken orally once daily with food		
	TRUVADA®	200mg (FTC) / 300mg(TDF)	one tablet taken orally once daily		
	ODEFSEY®	200/25/25mg	one tablet once daily with a meal		

PHYSICIAN INFORMATION

Physician Name _____ Contact Name _____
NPI # _____ DEA # _____ Lic # _____
Phone/Fax _____ E-mail _____
Address _____ City _____ State _____ Zip _____

I authorize to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature _____ **Date** _____

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