



**HIV**  
Please fax to  
**866.279.3315**

402 Wilkins Wise Road, Suite 38  
Columbus, MS 39705  
p. 866.279.3314

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

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

1. Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Relationship \_\_\_\_\_

2. Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Relationship \_\_\_\_\_

**CLINICAL INFORMATION** (please include most current lab results)

ICD-10 Code \_\_\_\_\_ Primary Diagnosis \_\_\_\_\_ Allergies:  Yes  No If yes, please list \_\_\_\_\_

Current Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ inches/cm BMI \_\_\_\_\_  Naive to Treatment Therapy  Experienced to Treatment Therapy

**MEDICATIONS**

	NAME	STRENGTH	DIRECTIONS	QTY	REFILL
<b>NRTIs</b>					
	DESCOVY	200/25mg			
	EMTRIVA	200mg			
	EPIVIR	150mg			
	EPZICOM	600/300mg			
	TRUVADA	200/300mg			
	VIREAD	300mg			
	ZIAGEN	300mg			
<b>NNRTIs</b>					
	EDURANT	25mg			
	INTELENCE	[ ] 25mg / [ ] 100mg / [ ] 200mg			

	SUSTIVA	<input type="checkbox"/> 50mg / <input type="checkbox"/> 200mg / <input type="checkbox"/> 600mg			
	VIRAMUNE XR™	400mg			

**Protease Inhibitors**

	EVOTAZ	<input type="checkbox"/> 300/150mg			
	INVIRASE	<input type="checkbox"/> 200mg / <input type="checkbox"/> 500mg			
	KALETRA	<input type="checkbox"/> 100/25mg <input type="checkbox"/> 200/50mg			
	LEXIVA	700mg			
	NORVIR	100mg			
	PREZCOBIX	800/150mg			
	PREZISTA	<input type="checkbox"/> 75mg / <input type="checkbox"/> 150mg / <input type="checkbox"/> 600mg / <input type="checkbox"/> 800mg			
	REYATAZ	<input type="checkbox"/> 150mg / <input type="checkbox"/> 200mg / <input type="checkbox"/> 300mg			
	VIRACEPT	<input type="checkbox"/> 250mg / <input type="checkbox"/> 625mg			

**Integrase Inhibitors**

	ISENTRESS	400mg			
	TIVICAY	50mg			

**Combination Single Tablet**

	ATRIPLA	600/200/300mg			
	BIKTARVY	50/125/200mg			
	COMPLERA	200/25/300mg			
	GENVOYA	150/150/200/10mg			
	ODEFSEY	200/25/25mg			
	STRIBILD	150/150/200/300mg			
	TRIUMEQ	600/50/300mg			

**PRESCRIBER INFORMATION**

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_  
\_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
\_\_\_\_\_  
NPI # \_\_\_\_\_ DEA # \_\_\_\_\_ Phone/ \_\_\_\_\_  
Fax \_\_\_\_\_

I authorize EntrustRx and its representatives 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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