



**HIV**  
Please fax to  
**855.273.3925**

2001 Campbell Station Pkwy STE A5  
Spring Hill, TN 37174  
p. 855.273.3924

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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