EntrustRx

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
NRTIs					
	DESCOVY	200/25mg			
	EMTRIVA	200mg			
	EPIVIR	150mg			
	EPZICOM	600/300mg			
	TRUVADA	200/300mg			
	VIREAD	300mg			
	ZIAGEN	300mg			
NNRTIs					
	EDURANT	25mg			
	INTELENCE	[ ] 25mg / [ ] 100mg / [ ] 200mg			

	SUSTIVA	[ ] 50mg / [ ] 200mg / [ ] 600mg			
	VIRAMUNE XR™	400mg			
Protease Inhibitors					
	EVOTAZ	[ ] 300/150mg			
	INVIRASE	[ ] 200mg / [ ] 500mg			
	KALETRA	[ ] 100/25mg [ ] 200/50mg			
	LEXIVA	700mg			
	NORVIR	100mg			
	PREZCOBIX	800/150mg			
	PREZISTA	[ ] 75mg / [ ] 150mg / [ ] 600mg / [ ] 800mg			
	REYATAZ	[ ] 150mg / [ ] 200mg / [ ] 300mg			
	VIRACEPT	[ ] 250mg / [ ] 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**_____