

HIV ENROLLMENT FORM

Fax: 270-247-6033

or 270-251-3571



DUNCAN
SPECIALTY PHARMACY

1522 Cuba Road
Mayfield, KY 42066
Phone: 270-247-3725

Today's Date:

Needs by Date:

Ship to: Patient Office Other:

Patient Information

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home & Cell #: _____
 SSN: _____
 DOB: _____ Sex: _____
 Patient Weight: _____ lbs or KG
 Drug Allergies: _____

Prescriber Information

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 DEA #: _____ State Lic#: _____
 NPI#: _____
 Phone: _____ Fax: _____
 Contact Person Name: _____
 Contact E-mail: _____

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic & Clinical Information

Diagnosis: B20HIV/AIDS B18.1 Chronic Hepatitis B18.2 Chronic Hepatitis C Other (include code): _____
 Labs: CD/4/T-Cell: _____ HIV RNA: _____ HCV genotype: _____ Viral Load: _____
 (copies of IU/mL) ALT: _____ Liver Biopsy Results: _____ Hgb/Hct: _____ WBC: _____ Test Date: _____

Prescription Information							
	DOSE & DIRECTIONS	QTY	REFILLS		DOSE & DIRECTIONS	QTY	REFILLS
NRTIs/NNRTIs				Combination Antiretroviral			
Descovy				Atripla			
Edurant				Combivir			
Emtriva				Complera			
EpiVir				Epzicom			
Intelence				Genvoya			
Retrovir				Odesfey			
Sustiva				Stribild			
Videx				Triumeq			
Viread				Trizivir			
Viramune				Truvada			
Zerit				Integrase Inhibitor/CCRS			
Ziagen				ISENTRESS			
Protease Inhibitors				TAF			
Aptivus				Selzentry			
Crixivan				Tivicay			
Evotaz				Vitekta			
Invirase				TAF			
Kaletra				Genvoya			
Entry Inhibitors				Other Medications			
Lexiva				Bactrim SS or DS			
Norvir				Dapsone			
Prezista				Diflucan			
Prezcobix				Ethambutol			
Reyataz				Famvir			
Viracept				Mepron Suspension			
Other				Other Medications			
Fuzeon				Procrit			
Selzentry				Tybost			
				Valtrex			
				Zithromax			
				Zovirax			

Prescriber Signature: _____ Date: _____

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