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HIVASSIST[®] ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 10.31.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Preferred Phone: _____ Alt. Phone: _____
 Last four digits of SS#: _____ Date of Birth: _____
 Gender: ___ Allergies: _____ Height: _____ Weight: _____

Provider Office: (Please provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____
 Specialty: _____ License#: _____ Tax ID#: _____
 Address: _____
 NPI: _____ DEA: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____ Office Contact: _____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) Patient's Address Always to Physician's Office First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis (Please provide ICD-10-CM codes) B20 HIV R64 Cachexia (HIV Wasting) E88.1 Lipodystrophy Other: _____

Clinical Information: Treatment Naïve Treatment Experienced HCV Positive: Yes No
 HIV RNA Viral Load: _____ CD4+ Count: _____ Other Medical Conditions: _____

Drug Name	Strength	Directions	Quantity	Refills	Drug Name	Strength	Directions	Quantity	Refills
Combination Tablets					Protease Inhibitors				
<input type="checkbox"/> Atripla [®]	600/200/300				<input type="checkbox"/> Aptivus [®]				
<input type="checkbox"/> Biktarvy [®]	50/200/25				<input type="checkbox"/> Crixivan [®]				
<input type="checkbox"/> Cimduo [®]	300/300				<input type="checkbox"/> Invirase [®]				
<input type="checkbox"/> Combivir [®]	150/300				<input type="checkbox"/> Kaletra [®]				
<input type="checkbox"/> Complera [®]	200/25/300				<input type="checkbox"/> Lexiva [®]				
<input type="checkbox"/> Descovy [®]	200/25				<input type="checkbox"/> Norvir [®]				
<input type="checkbox"/> Evotaz [®]	300/150				<input type="checkbox"/> Reyataz [®]				
<input type="checkbox"/> Epzicom [®]	600/300				<input type="checkbox"/> Viracept [®]				
<input type="checkbox"/> Genvoya [™]	150/150/200/10				Integrase Inhibitors				
<input type="checkbox"/> Juluca [®]	50/25				<input type="checkbox"/> Isentress [®]				
<input type="checkbox"/> Odefsey [®]	200/25/25				<input type="checkbox"/> Tivicay [®]				
<input type="checkbox"/> Prezcoibix [®]	800/150				NRTI				
<input type="checkbox"/> Stribild [®]	150/150/200/300				<input type="checkbox"/> Emtriva [®]				
<input type="checkbox"/> Symfi [®]	600/300/300				<input type="checkbox"/> Epivir [®]				
<input type="checkbox"/> Symfi Lo [®]	400/300/300				<input type="checkbox"/> Videx [®]				
<input type="checkbox"/> Symtuza [™]	800/150/200/10				<input type="checkbox"/> Viread [®]				
<input type="checkbox"/> Triumeq [®]	600/50/300				<input type="checkbox"/> Zerit [®]				
<input type="checkbox"/> Trizivir [®]	300/150/300				<input type="checkbox"/> Ziagen [®]				
<input type="checkbox"/> Truvada [®]	200/300				<input type="checkbox"/> Zidovudine [®]				
NNRTI					Entry Inhibitors				
<input type="checkbox"/> Edurant [®]					<input type="checkbox"/> Fuzeon [®]				
<input type="checkbox"/> Intelence [®]					<input type="checkbox"/> Selzentry [®]				
<input type="checkbox"/> Rescriptor [®]					Other Medications				
<input type="checkbox"/> Sustiva [®]					<input type="checkbox"/> Egrifta [®]				
<input type="checkbox"/> Viramune [®]					<input type="checkbox"/> Serostim [®]				
<input type="checkbox"/> ViramuneXR [®]					<input type="checkbox"/> Tybost [®]				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to Acro Commcare

Physician Signature: _____ DAW (Dispense as Written) **Date:** _____

Patient Support Programs: I authorize Acro Pharmaceutical Services and Commcare Specialty Pharmacy to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

*Patient Signature: (required for participation) _____ Date: _____ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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