ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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HIVASSIST®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

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
HIV RNA Viral Load:_____CD4+ Count:_____
HCV Positive: □Yes □No
Other Medical Conditions:_____

Drug Name	Strength	Directions	Quantity	Refills
Combination Tablets				
□Atripla®	600/200/300			
□Biktarvy®	50/200/25			
□Cimduo®	300/300			
□Combivir®	150/300			
□Complera®	200/25/300			
□Descovy®	200/25			
□Evotaz®	300/150			
□Epzicom®	600/300			
□Genvoya™	150/150/200/10			
□Juluca®	50/25			
□Odefsey®	200/25/25			
□Prezcobix®	800/150			
□Stribild®	150/150/200/300			
□Symfi®	600/300/300			
□Symfi Lo®	400/300/300			
□Symtuza™	800/150/200/10			
□Triumeq®	600/50/300			
□Trizivir®	300/150/300			
□Truvada®	200/300			
NNRTI				
□Edurant®				
□Intelence®				
□Rescriptor®				
□Sustiva®				
□Viramune®				
□ViramuneXR®				

Drug Name	Strength	Directions	Quantity	Refills
Protease Inhibitors				
□Aptivus®				
□Crixivan®				
□Invirase®				
□Kaletra®				
□Lexiva®				
□Norvir®				
□Reyataz®				
□Viracept®				
Integrase Inhibitors				
□Isentress®				
□Tivicay®				
NRTI				
□Emtriva®				
□Epivir®				
□Videx®				
□Viread®				
□Zerit®				
□Ziagen®				
□Zidovudine®				
Entry Inhibitors				
□Fuzeon®				
□Selzentry®				
Other Medications				
□Egrifta®				
□Serostim®				
□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