Infectious Disease Form
HIV-AIDS

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M F	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practitioner:		NPI:
Address:		
City		State/Zip
Office:		DEA:
Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION

Member Name:	M F	DOB:
Address:	City:	
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRESCRIPTION

New Refill | Ship by: | Ship to: Patient's Home Doctor's Office Other:_______________________

Drug	Strength
Single Tablet Regimens	
Atripla®	600/200/300mg
Biktarvy®	50/200/25mg
Complera®	200/25/300mg
Delstrigo®	100/300/300mg
Genvoya®	150/150/200/10mg
Juluca®	50/25mg
Odefsey®	200/25/25mg
Stribild®	150/150/200/300mg
Symfi®	600/300/300mg
Symfi Lo®	400/300/300mg
Symtuza®	800/150/200/10mg
Triumeq®	600/50/300mg
NRTI	
Cimduo®	300/300mg
Combivir®	150/300mg
Descovy®	200/25mg
Emtriva®	200mg
Epivir®	150mg 300 mg
Epzicom®	600/300mg
Trizivir®	300/150/300mg
Truvada®	200/300mg
Viread®	150 200 250 300
Ziagen	300mg
Zidovudine	100mg 300mg

Drug	Strength
Integrase Inhibitors	
Insentress®	400mg
Insentress HD®	600
Tivicay®	10 25 50mg
Pharmacokinetic Enhancers	
Norvir®	100mg
Tybost®	150mg
Protease Inhibitors	
Evotaz®	300/150mg
Kaletra®	200/50mg 100/25mg
Lexiva®	700mg
Prezcobix®	800/150mg
Prezista®	75 150 600 800mg
Reyataz®	50 150 200 300mg
Viracept®	250mg 625mg
NNRTI	
Edurant®	25mg
Intelence®	25 100 200mg
Pifeltro®	100mg
Sustiva®	50 200 600mg
Viramune®	100mg 400mg
Entry Inhibitors	
Fuzeon®	90mg vial
Selzentry®	150mg 200mg
Other	

Directions	Qty	Refills

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Diagnosis Description and ICD10:

Patient is new to therapy Patient is currently on therapy

Prior Medication Failed: ______________________________

Length of Treatment:______________________________

Reason for Discontinuation: ______________________________

Is this medication for HIV prevention? Yes No if for prevention: PrEP PEP

Recent HIV/RNA: ______________________ Date: ________________

Recebt CD4______________________ cells/mm 3 Date: ________________

HLA-B*5701 Present Reactive N/A

To assist with facilitating the prior authorization, pelase attach the following documents where appri-ate. Please indicate the documents attached:

Failed Therapies Recent laboratory results CCR5/CXCR4 Tropism Assay
Recent office notes Copy of front and back of insurance card

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	**Date:**