Cosentino's SPECIALTY CARE

HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Alt. Phone: ____________

Email: ______________________________

DOB: ________ Gender: ❍ M ❍ F Caregiver: ________

Height: ______ Weight: ______ Allergies: __________

2 PRESCRIBER INFORMATION:

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Fax: ____________

NPI: ____________ DEA: ____________

Tax I.D.: ______________________________

Office Contact: ____________ Phone: ____________

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3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Stage of HIV ❑ Stage I-Acute HIV Infection ❑ Stage II- Chronic HIV ❑ Stage III- AIDS ❑ Naive to Treatment Therapy ❑ Experienced to Treatment Therapy

ICD-10: ______________ Date of Diagnosis: ____________ Contraindications: ❑ No ❑ Yes ____________

Diagnosis Procedure(s) and Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:	
1. ❑ HIV-1 or ❑ HIV-2	________	❑ Positive	❑ Negative
2. Pre-exposure prophylaxis (PrEP):		❑ Yes	❑ No
3. CD4/T-cell	________	________	
4. HLA-B*5701 test:	________	________	
5. HIV RNA	________	________	
6. Viral Load	________	________	
7. Serum Creatinine:	________	________	
8. Pregnancy test:		❑ Positive	❑ Negative

Blood Results:

Date Drawn ________ Hgb/Hct: ________ WBC: ________

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 PATIENT TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY: ❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: ______________________________ Patient's Date of Birth: ____________

Medication				Dosage & Strength/Directions	QTY	Refills
NRTIs/NNRTIs						
❑ **DESCOVY®** 200/25mg ❑ For PrEP ❑ For adult treatment ❑ For pediatric treatment	❑ **EDURANT®** 25mg ❑ **EMTRIVA®** ❑ **EPIVIR®** ❑ **RETROVIR®**	❑ **SUSTIVA®** ❑ **VIRAMUNE®** ❑ **VIRAMUNE XR®** ❑ **VIREAD®**	❑ **ZERIT®** ❑ **ZIAGEN®**			
Protease Inhibitors						
❑ **APTIVUS®** 250mg ❑ **EVOTAZ®** 300/150mg ❑ **INVIRASE®**	❑ **KALETRA®** ❑ **LEXIVA®** ❑ **NORVIR®**	❑ **PREZISTA®** ❑ **REYATAZ®** ❑ **VIRACEPT®**				
Combinations						
❑ **ATRIPLA®** 600/200/300mg ❑ **BIKTARVY®** 50/200/25mg ❑ **COMBIVIR®** 150/300mg ❑ **COMPLERA®** 200/25/300mg ❑ **DELSTRIGO™** 100/300/300mg ❑ **DOVATO®** 50/300mg ❑ **EPZICOM®** 600/300mg	❑ **GENVOYA®** 150/150/200/10mg ❑ **JULUCA®** 50/25mg ❑ **ODEFSEY®** 200/25/25mg ❑ **PIFELTRO™** 100mg ❑ **PREZCOBIX®** 800/150mg ❑ **STRIBILD®** 150/150/200/300mg ❑ **SYMTUZA®** 800/150/200/10mg	❑ **TRIUMEQ®** 600/50/300mg ❑ **TRIZIVIR®** 300/150/300mg ❑ **TRUVADA®** ❑ For PrEP ❑ For adult treatment ❑ For pediatric treatment		❑ Take 1 tablet, once daily ❑ Take 1 tablet, twice daily ❑ Take 1 tablet, with a meal daily ❑ ____________		
Integrase Inhibitor/CCR5 I						
❑ **ISENTRESS®** 400mg	❑ **SELZENTRY®**	❑ **TIVICAY®** 50mg	❑ **VOCABRIA®**	❑ Take 1 tablet, twice daily ❑ ____________		
gp120 Attachment Inhibitor						
❑ **RUKOBIA** 600mg ER				❑ Take 1 tablet, twice daily		
Supportive Medications						
❑ Acyclovir ❑ Bactrim® (TMC/SMZ) ❑ Bactrim® DS(TMP/SMZ)	❑ Dapsone ❑ Diflucan® ❑ Fuzeon®	❑ Tybost® ❑ Valtrex® ❑ Zithromax®	❑ Other			

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ____________________ Date: ________ Signature: ____________________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.