



HIV Enrollment Form

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: Male Female
 Address: _____ City, State, ZIP Code: _____
 Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
 Primary Phone: _____ Alternate Phone: _____
 Email: _____ Last Four of SSN: _____ Primary Language: _____
 Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____ NPI #: _____ DEA #: _____
 Group or Hospital: _____
 Address: _____ City, State, ZIP Code: _____
 Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION (Attach copy of labs and clinical notes)

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

- B20 Human Immunodeficiency Virus (HIV) Disease Z29.81 - Encounter for HIV pre-exposure prophylaxis
 B18.0 Chronic Viral Hepatitis B with Delta Agent B18.1 Chronic Viral Hepatitis B without Delta-Agent
 B18.2 Chronic Viral Hepatitis C R64 Cachexia
 Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ lb/kg Height: _____ in/cm
 Treatment status: New to therapy Continuation of therapy: Date of last treatment ____/____/____
 CD4 Count _____ Baseline Viral load _____ Date of labs: _____
 Coinfection: None HCV HBV
 HLA-B*5701 test: Negative Positive

Nursing:

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No
 Site of Care: MD office Infusion Clinic / Outpatient Health Home Health

5 PRESCRIPTION INFORMATION

Single Regimen Oral:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Biktarvy	<input type="checkbox"/> 50/200/25 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Complera	<input type="checkbox"/> 200/25/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Delstrigo	<input type="checkbox"/> 100/300/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Dovato	<input type="checkbox"/> 50/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate*	<input type="checkbox"/> 600/200/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
*Brand no longer available for this drug			
<input type="checkbox"/> Genvoya	<input type="checkbox"/> 150/200/150/10 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Juluca	<input type="checkbox"/> 50/25 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Odefsey	<input type="checkbox"/> 200/25/25 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stribild	<input type="checkbox"/> 150/150/200/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Symfi	<input type="checkbox"/> 600/300/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Symfi Lo	<input type="checkbox"/> 400/300/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Symtuza	<input type="checkbox"/> 800/150/200/10 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Triumeq	<input type="checkbox"/> 600/50/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Triumeq PD	<input type="checkbox"/> 60/5/30 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Treatment status: New to therapy Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

Long-Acting Injectable:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Dedicated Apretude Team Phone Number: 1-855-801-8262		Fax Number: 1-866-279-1993	
<input type="checkbox"/> Apretude 600 mg Injection Kit	<input type="checkbox"/> 600 mg/3mL single-dose vial of cabotegravir	<input type="checkbox"/> Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter	Quantity: 1 dosing kit Refills: 1
<input type="checkbox"/> Apretude 600 mg Injection Kit	<input type="checkbox"/> 600 mg/3mL single-dose vial of cabotegravir	<input type="checkbox"/> Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
Dedicated Cabenuva Team Phone Number: 1-855-801-8262		Fax Number: 1-866-279-1993	
<input type="checkbox"/> Option 1: Every-2-Month Dosing			
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> Loading dose (Month 1 & Month 2): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle once monthly for 2 months then maintenance dose as directed	Quantity: 1 dosing kit Refills: 1
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> Maintenance dose (Month 4+): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
<input type="checkbox"/> Option 2: Every-1-Month Dosing			
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> Loading dose: Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle on day 1. Follow with maintenance dose in 1 month	Quantity: 1 dosing kit Refills: <u>0</u>
<input type="checkbox"/> Cabenuva 400/600 mg Injection Kit	<input type="checkbox"/> 400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	<input type="checkbox"/> Maintenance dose: Inject 2 mL of cabotegravir and 2 mL of rilpivirine into the muscle every month	Quantity: 1 dosing kit Refills: _____
Dedicated Sunlenca Team Phone Number: 1-877-602-5889		Fax Number: 1-877-733-3199	
<input type="checkbox"/> Sunlenca	<input type="checkbox"/> 300 mg tablets <input type="checkbox"/> 463.5 mg/1.5 mL vials	<input type="checkbox"/> Loading dose Option 1 927 mg by subcutaneous injection (2 x 1.5 mL injections) and 600 mg orally (2 x 300 mg tablets) on Day 1 Then 600 mg orally (2 x 300 mg tablets) on Day 2	<input type="checkbox"/> Loading dose 1 Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		<input type="checkbox"/> Loading dose Option 2 600 mg orally (2 x 300 mg tablets) on Day 1 600 mg orally (2 x 300 mg tablets) on Day 2 300 mg orally (1 x 300 mg tablet) on Day 8 Then 927 mg by subcutaneous injection (2 x 1.5 mL injections) on Day 15	<input type="checkbox"/> Loading dose 2 Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		<input type="checkbox"/> Maintenance Dose 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection (+/-2 weeks).	<input type="checkbox"/> Maintenance Quantity: (1) Injection dosing kit (contains 2 vials) Refills: <u>1</u>
<input type="checkbox"/> Trogarzo	N/A	Please complete a Trogarzo Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at https://www.trogarzo.com/hcp/patient-support/ or by calling 1-833-23-THERA (1-833-238-4372). Fax enrollment form to 1-855-836-3069.	N/A

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Treatment status: New to therapy Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

NRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cimduo	<input type="checkbox"/> 300/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lamivudine/ Zidovudine* *Brand no longer available for this drug	<input type="checkbox"/> 150/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Descovy	<input type="checkbox"/> 200/25 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Emtriva	<input type="checkbox"/> 200 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Efavir	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Abacavir/ Lamivudine* *Brand no longer available for this drug	<input type="checkbox"/> 600/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Retrovir	<input type="checkbox"/> 100 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Truvada	<input type="checkbox"/> 100/150 mg <input type="checkbox"/> 133/200 mg <input type="checkbox"/> 167/250 mg <input type="checkbox"/> 200/300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Viread	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Abacavir* *Brand no longer available for this drug	<input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zidovudine	<input type="checkbox"/> 100 mg <input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

NNRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Edurant	<input type="checkbox"/> 25 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Efavirenz	<input type="checkbox"/> 600 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Intelence	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Pifeltro	<input type="checkbox"/> 100mg tablet	<input type="checkbox"/> Take once daily with or without food	Quantity: _____ Refills: _____
<input type="checkbox"/> Sustiva	<input type="checkbox"/> 50 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Viramune	<input type="checkbox"/> 200 mg <input type="checkbox"/> 50 mg/ 5 mL	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Viramune XR	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Integrase Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Isentress	<input type="checkbox"/> 400 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Isentress HD	<input type="checkbox"/> 600 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tivicay	<input type="checkbox"/> 50 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tivicay PD	<input type="checkbox"/> 5 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Vocabria	N/A	All referrals must be sent through the HUB, ViiV Connect. Phone: 1-844-588-3288; Fax 1-844-208-7676	N/A

Entry Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Fuzeon	<input type="checkbox"/> 90 mg vial	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

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Prescriber Name: _____ Prescriber Phone: _____

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Protease Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Aptivus	<input type="checkbox"/> 250 mg <input type="checkbox"/> 100 mg/mL	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Eviator	<input type="checkbox"/> 300/150 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Kaletra	<input type="checkbox"/> 100/25 mg <input type="checkbox"/> 200/50 mg <input type="checkbox"/> 80 mg – 20 mg/mL	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Fosamprenavir* *Brand no longer available for this drug	<input type="checkbox"/> 700 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Norvir	<input type="checkbox"/> 100 mg <input type="checkbox"/> 80 mg/mL	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prezcoibx	<input type="checkbox"/> 800/150 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prezista	<input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Reyataz	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Viracept	<input type="checkbox"/> 250 mg <input type="checkbox"/> 625 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Attachment Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Rukobia	600 mg Extended-Release	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Pharmacokinetic Enhancer:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Tybost	<input type="checkbox"/> 150 mg	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Metabolic Support:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Egrifta SV	N/A	Please complete an Egrifta SV Patient Enrollment and Consent Form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at https://hcp.egriftasv.com/ or by calling 1-833-23-THERA (1-833-238-4372). Fax enrollment form to 1-855-836-3069.	N/A
<input type="checkbox"/> Serostim	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Supportive Therapy:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Bactrim	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Diflucan	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Mytesi	125 mg tablet	<input type="checkbox"/> Take twice daily with or without food	Quantity: _____ Refills: _____

Other:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Other: _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

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