



# HIV Enrollment Form

Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

NCPDP: 4026325

## 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: _____

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

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## 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
<b>Dedicated Apretude Team Phone Number: 1-855-801-8262</b>		<b>Fax Number: 1-866-279-1993</b>	
<input type="checkbox"/> Apretude 600 mg Injection Kit	<input type="checkbox"/> 600 mg/3mL single-dose vial of cabotegravir	<input type="checkbox"/> <b>Loading dose</b> (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"/> <b>Maintenance dose</b> (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
<b>Dedicated Cabenuva Team Phone Number: 1-855-801-8262</b>		<b>Fax Number: 1-866-279-1993</b>	
<input type="checkbox"/> <b>Option 1: Every-2-Month Dosing</b>			
<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"/> <b>Loading dose</b> (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"/> <b>Maintenance dose</b> (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"/> <b>Option 2: Every-1-Month Dosing</b>			
<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"/> <b>Loading dose:</b> 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"/> <b>Maintenance dose:</b> Inject 2 mL of cabotegravir and 2 mL of rilpivirine into the muscle every month	Quantity: 1 dosing kit Refills: _____
<b>Dedicated Sunlenca Team Phone Number: 1-877-602-5889</b>		<b>Fax Number: 1-877-733-3199</b>	
<input type="checkbox"/> Sunlenca	<input type="checkbox"/> 300 mg tablets <input type="checkbox"/> 463.5 mg/1.5 mL vials	<input type="checkbox"/> <b>Loading dose Option 1</b> 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"/> <b>Loading dose 1</b> Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		<input type="checkbox"/> <b>Loading dose Option 2</b> 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"/> <b>Loading dose 2</b> Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		<input type="checkbox"/> <b>Maintenance Dose</b> 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"/> <b>Maintenance</b> 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 <a href="https://www.trogarzo.com/hcp/patient-support/">https://www.trogarzo.com/hcp/patient-support/</a> 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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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

#### 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"/> Prezobix	<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 <a href="https://hcp.egriftasv.com/">https://hcp.egriftasv.com/</a> 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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**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Pharmacy, Inc. or one of its affiliates.