JOSEFS PHARMACY

HIV ENROLLMENT FORM

TOLL FREE: 855-326-9112 | FAX: 844-965-9633 or 855-326-9114 | WEB: JosefsPharmacy.com

PATIENT STATUS	PACKAGING	DELIVERY	
☐New Patient ☐Current Patient ☐New RX ☐Refill ☐Medicare/Medicaid Primary Caregiver:	☐ Josef Compliance Packaging ☐ Vials (Child Proof ☐ Yes ☐ No)	☐Patient's home ☐Pharmacy pickup ☐MD's office ☐ 1st dose at MD's office and remaining refills at patient's home	Date Needed:

PATIENT INFO	PRESCRIBER INFO
Last Name, First Name Primary Language	Today's Date
Best Phone Number ( ) Alternate Phone Number ( )	Physician Name NPI #
Home Address City, State Zip	State License # DEA #:
Shipping Address (if different from home address)	Address City, State Zip
Social Security Number Date of Birth	Phone Number ( ) Fax Number ( )
Height Weight BMI Gender ☐ M ☐ F Pregnant ☐ Yes ☐ No	Key Office Contact Name Email

CLINICAL INFORMATION | PLEASE FAX LABS, CURRENT MEDICATIONS/OTC PROFILE AND HISTORY

Diagnosis (ICD9): ☐042 HIV/AIDS ☐079.53 HIV-2 ☐070.32 HBV (Chronic) ☐070.54 HCV (Chronic) Other: Date of Diagnosis:

New to current therapy? ☐Yes ☐No CD4: Date: HIV RNA: Date: Known Drug Allergies:

Prior/Current Medications:

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
Aptivus® (tipranavir)	250mg	Two capsules by mouth BID (Q12 hours)		
Atripla® (EFV/FTC/TDF)	600mg/200mg/300 mg	One tablet by mouth QD on an empty stomach		
Combivir® (lamivudine/zidovudine)	150mg/300mg	One tablet by mouth BID (Q12 hours)		
Complera® (FTC/rilpivirine/TDF)	200mg/25mg/300 mg	One tablet by mouth QD with food		
Crixivan® (indinavir)				
Edurant® (rilpivirine)	25mg	One tablet by mouth QD with a meal		
Emtriva® (emtricitabine)	200mg	One capsule by mouth QD		
Epivir® (lamivudine)				
Epzicom® (abacavir/lamivudine)	600mg/300mg	One tablet by mouth QD		
Fuzeon® (enfuvirtide)	90mg	90 mg (1mL) Sub-Q BID (Q12 hours)		
Intelence® (etravirine)				
Invirase® (saquinavir)				
Isentress® (raltegravir)	400mg	One tablet by mouth BID (Q12 hours)		
Kaletra® (lopinavir/ritonavir)	200mg/50mg			
Lexiva® (fosamprenavir)	700mg			
Norvir® (ritonavir) tablets	100mg			
Prezista® (darunavir)				
Rescriptor® (delavirdine)				
Retrovir® (zidovudine)				
Reyataz® (atazanavir)				
Selzentry® (maraviroc)				
Stribild™ (EVG/COBI/FTC/TDF)	150/150/200/300 mg	One tablet by mouth QD with food		
Sustiva® (efavirenz)				
Tivicay® (dolutegravir)	50mg			
Trizivir® (ABC/3TC/AZT)	300/150/300mg	One tablet by mouth BID (Q12 hours)		
Truvada® (emtricitabine/tenofovir)	200/300mg	One tablet by mouth QD		
Valcyte (Valganclclovir Hydrochloride)	900mg	☐ Induction: Twice Daily for Days ☐ Maintenance: once daily after induction ☐ Other:		
Videx® EC (didanosine)				
Viracept® (nelfinavir)				
Viramune® (nevirapine)	200mg			
Viramune® XR™ (nevirapine ER)	400mg	One tablet by mouth QD		
Viread® (tenofovir)	300mg			
Zerit® (stavudine)				
Ziagen® (abacavir)	300mg			
Other Medication (Please Specify):				

Other Medications

☐ Acyclovir Bactrim® (TMP/SMZ)

☐ Bactrim® DS (TMP/SMZ)

☐ Dapsone

☐ Diflucan® (fluconazole)

☐ Egrifta®

☐ Serostim® (somatropin)

☐ Valtrex® (valacyclovir)

☐ Zithromax® (azithromycin)

Strength:

Directions:

Qty:

Refills:

Injection Training

Josefs Pharmacy to coordinate subcutaneous training for:

☐ Fuzeon®
☐ Egrifta®
☐ Serostim®

I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies and to coordinate/receive patient lab values.

☐ Patient is interested in Patient Support Programs as necessary/applicable *Ancillary kits and supplies provided as necessary/applicable*

_____ _____

Doctor/Prescriber Signature – Dispense as Written Date Doctor/Prescriber Signature – Substitution Permissible Date