GIANT EAGLE Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

HIV ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No

Patient Information

Date: _____ ☐ Male ☐ Female DOB:_____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Clinical Info.

Diagnosis ICD-10:_____ ☐ HIV/AIDS ☐ HIV2 ☐ HBV (Chronic) ☐ HCV (Chronic)
New to current therapy? ☐ yes ☐ no CD4: _____ date: _____ HIV RNA: _____ date: _____

Prescription

SINGLE TABLE REGIMEN

Atripla 600/300/200mg tabs
Dispense ___ days supply
Take 1 tablet once daily
Refill x _____

Biktarvy 50mg/200mg/25mg
Dispense ___ days supply
Take 1 tablet daily
Refill x _____

Complera 200mg/25mg/300mg
Dispense ___ days supply
Take 1 tablet once daily with a meal
Refill x _____

Genvoya 150mg/150mg/200mg/10mg
Dispense ___ days supply
Take 1 tablet once daily
Refill x _____

Juluca 50mg/25mg
Dispense ___ days supply
Take 1 tablet once daily
Refill x _____

Stribild 150mg/150mg/200mg/200mg
Dispense ___ days supply
Take 1 tablet once daily
Refill x _____

INTEGRASE INHIBITORS

Isentress 400mg tabs
Dispense ___ days supply
Take 1 tab 2 x daily
Refill x _____

Isentress HD 600mg tabs
Dispense ___ days supply
Take 2 tabs once daily
Refill x _____

Tivicay 50mg
Dispense ___ days supply
Take ___ tab ___ x daily
Refill x _____

NRTIs

Combivir 150/300mg tabs
Dispense ___ days supply
Take 1 tab twice daily
Refill x _____

Descovy 200/25 tabs
Dispense ___ days supply
Take 1 tab once daily
Refill x _____

Epzicom 600mg/300mg tabs
Dispense ___ days supply
Take 1 tab once daily
Refill x _____

Truvada 200mg/300mg tabs
Dispense ___ days supply
Take 1 tab once daily
Refill x _____

PI

Kaletra 200/50mg tabs
Dispense ___ days supply
Take 2 tabs twice daily
Refill x _____

Norvir 100mg tabs
Dispense ___ days supply
Take ___ tabs ___ x daily
Refill x _____

Prezcobix 800/150mg
Dispense ___ days supply
Take 1 tablet daily
Refill x _____

Reyataz _____mg caps
Dispense ___ days supply
Take ___ caps ___ x daily
Refill x _____

FUSION AND ENTRY INHIBITORS

Selzentry _____mg tabs
Dispense ___ days supply
Take ___ tablets 2 x daily
Refill x _____

NNRTIs

Edurant 25mg tabs
Dispense ___ days supply
Take ___ tabs ___ x daily
Refill x _____

Intelence _____mg tabs
Dispense ___ days supply
Take ___ tabs ___ x daily
Refill x _____

Sustiva 600mg tabs
Dispense ___ days supply
Take 1 tab at bedtime
Refill x _____

OTHER MEDICATION

_____
Dispense ___ days supply
Directions: _____
Refill x _____

_____
Dispense ___ days supply
Directions: _____
Refill x _____

_____
Dispense ___ days supply
Directions: _____
Refill x _____

_____
Dispense ___ days supply
Directions: _____
Refill x _____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____