HIV Enrollment Form

CVS specialty®

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
☐ Biktarvy	☐ 50/200/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Complera	☐ 200/25/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Delstrigo	☐ 100/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Dovato	☐ 50/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate* *Brand no longer available for this drug	☐ 600/200/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Genvoya	☐ 150/200/150/10 mg	☐ _____	Quantity: _____ Refills: _____
☐ Juluca	☐ 50/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Odefsey	☐ 200/25/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Stribild	☐ 150/150/200/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symfi	☐ 600/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symfi Lo	☐ 400/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symtuza	☐ 800/150/200/10 mg	☐ _____	Quantity: _____ Refills: _____
☐ Triumeq	☐ 600/50/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Triumeq PD	☐ 60/5/30 mg	☐ _____	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
Prescriber's Signature: _____Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____

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.

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Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Patient Address: _____
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**	
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ **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
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ **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**	
☐ **Option 1: Every-2-Month Dosing**			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ **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
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ **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: _____
☐ **Option 2: Every-1-Month Dosing**			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ **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: 0
☐ Cabenuva 400/600 mg Injection Kit	☐ 400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	☐ **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**	
☐ Sunlenca	☐ 300 mg tablets ☐ 463.5 mg/1.5 mL vials	☐ **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	☐ **Loading dose 1** Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: 0
		☐ **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	☐ **Loading dose 2** Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: 0
		☐ **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).	☐ **Maintenance** Quantity: (1) Injection dosing kit (contains 2 vials) Refills: 1
☐ 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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Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment _____/_____/_____

5 PRESCRIPTION INFORMATION

NRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cimduo	☐ 300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Lamivudine/ Zidovudine* *Brand no longer available for this drug	☐ 150/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Descovy	☐ 200/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Emtriva	☐ 200 mg	☐ _____	Quantity: _____ Refills: _____
☐ Epivir	☐ 150 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Abacavir/ Lamivudine* *Brand no longer available for this drug	☐ 600/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Retrovir	☐ 100 mg	☐ _____	Quantity: _____ Refills: _____
☐ Truvada	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Viread	☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Abacavir* *Brand no longer available for this drug	☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Zidovudine	☐ 100 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____

NNRTIs:

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

Integrase Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Isentress	☐ 400 mg	☐ _____	Quantity: _____ Refills: _____
☐ Isentress HD	☐ 600 mg	☐ _____	Quantity: _____ Refills: _____
☐ Tivicay	☐ 50 mg	☐ _____	Quantity: _____ Refills: _____
☐ Tivicay PD	☐ 5 mg	☐ _____	Quantity: _____ Refills: _____
☐ 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
☐ Selzentry	☐ 150 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____

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5 PRESCRIPTION INFORMATION

Protease Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aptivus	☐ 250 mg ☐ 100 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Evotaz	☐ 300/150 mg	☐ _____	Quantity: _____ Refills: _____
☐ Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Fosamprenavir* *Brand no longer available for this drug	☐ 700 mg	☐ _____	Quantity: _____ Refills: _____
☐ Norvir	☐ 100 mg ☐ 80 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Prezcobix	☐ 800/150 mg	☐ _____	Quantity: _____ Refills: _____
☐ Prezista	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg	☐ _____	Quantity: _____ Refills: _____
☐ Reyataz	☐ 150 mg ☐ 200 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Viracept	☐ 250 mg ☐ 625 mg	☐ _____	Quantity: _____ Refills: _____

Attachment Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Rukobia	600 mg Extended-Release	☐ _____	Quantity: _____ Refills: _____

Pharmacokinetic Enhancer:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tybost	☐ 150 mg	☐ _____	Quantity: _____ Refills: _____

Metabolic Support:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ 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
☐ Serostim	☐ _____	☐ _____	Quantity: _____ Refills: _____

Supportive Therapy:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Bactrim	☐ _____	☐ _____	Quantity: _____ Refills: _____
☐ Diflucan	☐ _____	☐ _____	Quantity: _____ Refills: _____
☐ Mytesi	125 mg tablet	☐ Take twice daily with or without food	Quantity: _____ Refills: _____

Other:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ _____	☐ _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ _____	☐ _____	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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