BLUEGRASS PHARMACY | HIV CO-INFECTION ENROLLMENT FORM



FAX FORM TO: 1.866.233.8317 | PHONE: 1.855.492.0817 | EMAIL: contact@bluegrass-rx.com

Complete the following or include demographic sheet.

Complete the following of include demog	пиртис з	nices.									
1. PATIENT INFORMATION						2. PRESCRIBER INFORMATION					
Name:					1	Name:					
Address:						DEA #:		NPI #:	State Lic. #:		
City, State, ZIP:						Group or Hospital:					
Primary Phone: DOB: / /						Address:					
Alternate Phone:	Gender:			City, State, Zip:							
Email:						Phone: Fax:					
Primary Language: Last Four of SSI					Contact Person: Ph						
3. INSURANCE INFORMATION	1		Fa.	x copy of p i	rescript	tion ar	nd insu	ırance cards with this form, if av	ailable (front a	nd back)	
Primary Insurance Company Name:					9	Second	dary Insu	urance Company Name:			
Primary Cardholder Name:					Secondary Cardholder Name:						
Relationship: Self Spouse/Partner Child/Dependent					Relationship: O Self O Spouse/Partner O Child/Dependent						
Phone: Member ID:			Group #:						· · · · · · · · · · · · · · · · · · ·		
4. DIAGNOSIS AND CLINICAL	INFOR	MATION									
Needs by Date: / /	Ship to:	Patient Office Other:									
Date of Diagnosis: / /		LAB DATA						Patient evaluation - Hepatitis C			
○ B2Ø HIV / AIDS				Lab value	Baselir	Baseline Curren		HCV RNA (Baseline):IU/ml	Date of	lab: / /	
B18.1 Chronic viral hepatitis B		CD4/T-cell cou	ınt:					HCV RNA (12 weeks, if applicable):	_IU/ml Date of	lab: / /	
B18.2 Chronic viral hepatitis C		HIV RNA:						HCV genotype: O 1a O 1b O 1			
R64 Cachexia (HIV wasting)		HGB/HCT:						Has patient been previously treated for hepatitis C? Yes			
Specialty pharmacy to coordinate injection training/home health nurse visit as necessary?		White blood cell count:						Does patient suffer from uncontrolled/life-threatening			
Yes No Agency of choice:	If taking ribavirin, is the patient (or patient's patient)			nt's partne	artner) pregnant		neuropsychiatric, autoimmune, ischemic, or infectious disorders,				
Injection training not necessary	or unwilling to use adequate contraception,						or have a hx of autoimmune hepatitis or hepatic decompensation?				
Reason: MD office trained patie	hemoglobinopathies or renal insufficiency (c				rcl<50 ml/min)?		Yes No				
Patient already indepe	○ Yes ○ No						Has patient had liver biopsy? Ye	s O No			
Referred by MD office	Allergies:						Biopsy Date/Results: / /				
alternate trainer	Other Medications:										
	Height (in/cm): Weight (lb/kg):										
5. PRESCRIPTION INFORMATI	ON										
Medication	/Strength Directions							Quantity	Refills		
Ancillary supplies and kits will be prov	ided as	needed for adm	inistratio	on.							
6. PRESCRIBER SIGNATURE											
x			/	/ /	X					/ /	
DISPENSE AS WRITTEN			DATE PRODUCT SUBSTITUTION PERMITTED DATE								

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