WELLPARTNER PHARMACY | HIV ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

- ◯ B20 HIV / AIDS
- ◯ B18.1 Chronic viral hepatitis B w/o delta-agent
- ◯ B18.2 Chronic viral hepatitis C
- ◯ R64 Cachexia (HIV wasting)
- ◯ Other (Specify):

Treatment: ◯ Naïve ◯ Experienced

Height (in/cm): Weight (lb/kg): BMI:

LAB DATA

	Baseline Lab Value	Date	Baseline Lab Value	Date
HIV RNA:		/ /		/ /
CD4/T cell:				
Hgb:		/ /		/ /

If applicable, HLA-B*5701: Results: Date: / /

Allergies:

Other Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills
◯ Atripla	300/200/600				◯ Procrit				
◯ Combivir	300/150				◯ Reyataz				
◯ Complera	300/200/25				◯ Selzentry				
◯ Descovy					◯ Stribild	150/150/200/300			
◯ Edurant					◯ Sustiva				
◯ Emtriva	200 mg				◯ Tivicay				
◯ Epivir					◯ Trizivir	300/150/300			
◯ Epzicom™	600/300				◯ Triumeq				
◯ Evotaz					◯ Truvada	300/200			
◯ Genvoya					◯ Tybost				
◯ Intelence	100 mg				◯ Videx EC				
◯ Isentress	400 mg				◯ Viracept				
◯ Kaletra	200/50				◯ Viramune XR				
◯ Lexiva	700 mg				◯ Viread	300 mg			
◯ Norvir	100 mg				◯ Zerit				
◯ Odefsey					◯ Ziagen				
◯ Precobix					◯				
◯ Prezista					◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE