WELLPARTNER PHARMACY | HIV CO-INFECTION 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: / /

◯ B2Ø HIV / AIDS
◯ B18.1 Chronic viral hepatitis B
◯ B18.2 Chronic viral hepatitis C
◯ R64 Cachexia (HIV wasting)

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary?
◯ Yes ◯ No Agency of choice:

◯ Injection training not necessary
Reason: ◯ MD office trained patient
◯ Patient already independent
◯ Referred by MD office to alternate trainer

LAB DATA

	Lab value	Baseline	Current
CD4/T-cell count:			
HIV RNA:			
HGB/HCT:			
White blood cell count:			

If taking ribavirin, is the patient (or patient's partner) pregnant or unwilling to use adequate contraception, or is there a hx of hemoglobinopathies or renal insufficiency (crcl<50 mL/min)?
◯ Yes ◯ No

Allergies:
Other Medications:
Height (in/cm): Weight (lb/kg):

Patient evaluation - Hepatitis C

HCV RNA (Baseline): _____ IU/ml Date of lab: / /
HCV RNA (12 weeks, if applicable): ____ IU/ml Date of lab: / /
HCV genotype: ◯ 1a ◯ 1b ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6
Has patient been previously treated for hepatitis C? ◯ Yes ◯ No
Does patient suffer from uncontrolled/life-threatening neuropsychiatric, autoimmune, ischemic, or infectious disorders, or have a hx of autoimmune hepatitis or hepatic decompensation?
◯ Yes ◯ No
Has patient had liver biopsy? ◯ Yes ◯ No
Biopsy Date/Results: / /

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills

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

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE