Medley Pharmacy
Sinks Pharmacy
Towne Pharmacy
Steelville Drug
SpecialtyCARE Services

HUMAN IMMUNODEFICIENCY VIRUS SPECIALTY CARE PROGRAM

Phone: 844-422-6400 • Fax: 888-850-4018

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ **State:** ____ **Zip:** _____
Phone: _____ **Alt. Phone:** _____
Email: _____
DOB : _____ **Gender:** ❍ M ❍ F **Caregiver:** _____
Height: _____ **Weight:** _____ **Allergies:** _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ **State:** ____ **Zip:** _____
Phone: _____ **Fax:** _____
NPI: _____ **DEA:** _____
Tax I.D.: _____
Office Contact: _____ **Phone:** _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

ICD-10: _____ **Date of Diagnosis:** _____ **Contraindications:** ❑ No ❑ Yes _____

Diagnosis Procedure(s) or Laboratory Test(s) :

Test/Procedure:	Date Performed:	Results:
1. CD/4/T-cell		
2. HIV RNA		
3. Viral Load		
4. Liver Biopsy		

Blood Results:
Date Drawn _____ Hgb/Hct: _____ WBC: _____

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

4 PRESCRIPTION INFORMATION:

Medication				Dosage & Strength/Directions	QTY	Refills
NRTIs/NNRTIs						
❑ EDURANT ® 25mg	❑ RESCRIPTOR ®	❑ VIRAMUNE ®	❑ ZIAGEN ®			
❑ EMTRIVA ®	❑ RETROVIR ®	❑ VIRAMUNE XR ®				
❑ EPIVIR ®	❑ SUSTIVA ®	❑ VIREAD ®				
❑ INTELENCE ®	❑ VIDEX ®	❑ ZERIT ®				
Protease Inhibitors						
❑ APTIVUS ® 250mg	❑ INVIRASE ®	❑ PREZISTA ®				
❑ CRIXIVAN ®	❑ KALETRA ® 200/50mg	❑ REYATAZ ®		❑ _____		
❑ EVOTAZ ™ 300/150mg	❑ LEXIVA ®	❑ VIRACEPT ®				
❑ NORVIR ® 100mg Capsules	❑ NORVIR ® 100mg Tablets			❑ Take 2, twice daily (❑ Capsules ❑ Tablets)		
Combinations						
❑ ATRIPLA ® 600/200/300mg	❑ GENVOYA ® 150/150/200/10mg	❑ TRIUMEQ ® 600/50/300mg		❑ Take 1 tablet, once daily		
❑ COMBIVIR ® 150/300mg	❑ ODEFSEY ® 200/25/25mg	❑ TRIZIVIR ® 300/150/300mg		❑ Take 1 tablet, twice daily		
❑ COMPLERA ® 200/25/300mg	❑ PREZCOBIX ® 800/150mg	❑ TRUVADA ® 200/300mg		❑ Take 1 tablet, with a meal daily		
❑ EPZICOM ® 600/300mg	❑ STRIBILD ® 150/150/200/300mg			❑ _____		
Integrase Inhibitor/CCR5 I						
❑ ISENTRESS ® 400mg	❑ SELZENTRY ®	❑ TIVICAY ® 50mg	❑ VITEKTA ™	❑ Take 1 tablet, twice daily		
				❑ _____		
Supportive Medications						
❑ Acyclovir	❑ Dapsone	❑ Tybost ®	❑ Other			
❑ Bactrim ® (TMC/SMZ)	❑ Diflucan ®	❑ Valtrex ®				
❑ Bactrim ® DS(TMP/SMZ)	❑ Fuzeon ®	❑ Zithromax ®				

5 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION:

Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ **Date:** _____ **Signature:** _____ **Date:** _____

Substitution Permitted Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.