ATLANTIC SPECIALTY DRUGS

HIV Enrollment Form

Phone: 562-912-7940
Fax: 562-912-7944
4233 Atlantic ave, Long Beach, CA 90807

patient information

patient: _____ (last name, first name) male female DOB: _____ SS#: _____

address: _____ (street, city, state, zip)

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs kg date: _____

clinical information

Diagnosis ICD-10: B20 HIV B18.0 HBV with delta agent (Chronic) B18.1 HBV without delta agent (Chronic) B18.2 HCV (Chronic)

New to current therapy? yes no CD4: _____ date: _____ HIV RNA: _____ date: _____

prescriptions

medication	QTY	refills
Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)		
Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empy stomach		
Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)		
Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food		
Crixivan® (indinavir) One tablet by mouth QD with a meal		
Edurant™ (rilpivirine) 25 mg One capsule by mouth QD		
Emtrivia® (emtricitabine) 200 mg		
Epivir® (lamivudine)		
Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD		
Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
Intelence® (entravirine)		
Invirase® (saquinavir)		
Isentress® (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)		
Kaletra® (lopinavir/ritonavir) 200/50 mg		
Laxiva® (fosamprenavir) 200/50 mg		
Norvir® (ritonavir) capsules 100 mg		
Norvir® (ritonavir) tablets 100 mg		
Prezista® (darunavir)		
Rescriptor® (delavirdine)		

medication	QTY	refills
Retrovir® (zidovudine)		
Reyataz® (atazanavir)		
Selzentry® (maraviroc)		
Stribid™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
Sustiva® (efavirenz)		
Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
Videx® EC (didanosine)		
Viracept® (nelfinavir)		
Viramune® (nevirapine) 200 mg		
Viramune® XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
Viread® (tenofovir) 300 mg		
Zerit® (stavudine)		
Ziagen® (avacavir) 300 mg		
other medications		
Acylovir		
Bactrim® (TMC/SMZ)		
Bactrim® DS(TMP/SMZ)		
Dapsone		
Diflucan® (fluconazole)		
Serostim® (somatropin)		
Valtrex® (valacyclovir)		
Zithromax® (azithromycin)		

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate _____ (shipping address: street, city, state, zip)

office address: _____ (street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Atlantic Drugs and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Atlantic Drugs.

insurance information: please fax copy of insurance card (front + back)

Updated on 02/18/16