HIV Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Medina, Ohio.

PATIENT INFORMATION

Patient Name _____
DOB ___/___/_____ SSN _____ Gender_____
Weight _____ Height _____ Phone _____
Address _____
City, State, Zip _____
Cell Phone _____ E-Mail _____

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____
Insurance Co. Phone _____ Group# _____

Policy Holder Name _____
Policy Holder Employer _____
Relationship to Patient _____
ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____
Practice Name _____
State License#_____ UPIN _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ Date Diagnosed _____ ICD-10 Code _____
Viral Load _____ Date Measured _____ HBV or HCV Positive? _____ YES _____ NO
Serum Creatinine _____ CD4/T-Cell Count _____ WBC Count _____ Date Measured _____
Drug Allergies _____ Latex Allergy _____ YES _____ NO
Other Disease States or Comorbities _____ HIV Wasting? ____ YES ____ NO
Any previous treatment? _____ YES _____ NO Dates and viral load results _____
Additional Comments _____

PRESCRIPTION INFORMATION *(please indicate if brand name is required)*

Medication	Dose	SIG	QTY	Refills
Protease Inhibitors				
Crixivan®				
Invirase®				
Kaletra®	200/50			
Lexiva®	700mg			
Norvir® tab	100mg			
Prezista®				
Reyataz®				
Viracept®				
Integrase Inhibitors				
Isentress®				
Tivicay®	50mg			
Vitekta®				
Comibination Antiretrovirals				
Atripla®	300/200/600			
Combivir®	300/150			
Complera®	300/200/25			
Descovy®	200/25			
Epzicom®	600/300			
Evotaz™	300/150			
Genvoya®	150/150/200/10			
Odefsey®	200/25/25			
Prezcobix™	800/150			
Stribild™	150/150/200/300			
Triumeq®	600/50/300			
Trizivir®	300/150/300			
Truvada®	300/199			

Medication	Dose	SIG	QTY	Refills
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)				
Emtriva®	200mg			
Epivir®				
Retrovir®				
Videx EC®	300mg			
Viread®				
Zerit®				
Ziagen®				
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)				
Edurant™				
Intelence®	100mg			
Rescriptor®				
Sustiva®				
Viramune XR®				
Entry Inhibitors				
Fuzeon®				
Selzentry®				
Other Related Medications				
Dapsone®				
Valtrex®				
Zovirax®				
Procrit®				
Serostim®				
TYBOST®	150mg			

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.