HIV Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447 ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, 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 ______________________________

DEA ____________________ NPI ____________________

Address ______________________________

City, State, Zip ______________________________

Phone ____________________ Fax ____________________

Office Contact Person ______________________________

Office Contact EMAIL ______________________________

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

Medication	Dose	SIG	QTY	Refills
Atripla®	300/200/600			
Biktarvy®	50/200/25			
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			
Rukobia	600mg ER			
Stribild®	150/150/200/300			
Symtuza®	800/150/200/10			
Triumeq®	600/50/300			
Trizivir®	300/150/300			
Truvada®	300/199			

Other Meds	Dose	SIG	QTY	Refills

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.