



HIV Enrollment Form

Fax Referral To: 1-877-232-5455

Address: 3375 Koapaka Street, Suite D105, Honolulu, HI 96819

Phone: 1-808-254-2727

NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____ NPI #: _____ DEA #: _____

Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION (Attach copy of labs and clinical notes)

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ B20 Human Immunodeficiency Virus (HIV) Disease ☐ Z29.81 - Encounter for HIV pre-exposure prophylaxis

☐ B18.0 Chronic Viral Hepatitis B with Delta Agent ☐ B18.1 Chronic Viral Hepatitis B without Delta-Agent

☐ B18.2 Chronic Viral Hepatitis C ☐ R64 Cachexia

☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ lb/kg Height: _____ in/cm

Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment ____/____/____

CD4 Count _____ Baseline Viral load _____ Date of labs: _____

Coinfection: ☐ None ☐ HCV ☐ HBV

HLA-B*5701 test: ☐ Negative ☐ Positive

Nursing:

Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No

Site of Care: ☐ MD office ☐ Infusion Clinic / Outpatient Health ☐ Home Health

5 PRESCRIPTION INFORMATION

Single Regimen Oral:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Biktarvy	☐ 50/200/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Complera	☐ 200/25/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Delstrigo	☐ 100/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Dovato	☐ 50/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate*	☐ 600/200/300 mg	☐ _____	Quantity: _____ Refills: _____
*Brand no longer available for this drug			
☐ Genvoya	☐ 150/200/150/10 mg	☐ _____	Quantity: _____ Refills: _____
☐ Juluca	☐ 50/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Odefsey	☐ 200/25/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Stribild	☐ 150/150/200/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symfi	☐ 600/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symfi Lo	☐ 400/300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Symtuza	☐ 800/150/200/10 mg	☐ _____	Quantity: _____ Refills: _____
☐ Triumeq	☐ 600/50/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Triumeq PD	☐ 60/5/30 mg	☐ _____	Quantity: _____ Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: _____ Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Patient Address: _____
 Prescriber Name: _____ Prescriber Phone: _____
 Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

Long-Acting Injectable:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Dedicated Apretude Team Phone Number: 1-855-801-8262 Fax Number: 1-866-279-1993			
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter	Quantity: 1 dosing kit Refills: 1
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
Dedicated Cabenuva Team Phone Number: 1-855-801-8262 Fax Number: 1-866-279-1993			
☐ Option 1: Every-2-Month Dosing			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Loading dose (Month 1 & Month 2): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle once monthly for 2 months then maintenance dose as directed	Quantity: 1 dosing kit Refills: 1
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Maintenance dose (Month 4+): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
☐ Option 2: Every-1-Month Dosing			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Loading dose: Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle on day 1. Follow with maintenance dose in 1 month	Quantity: 1 dosing kit Refills: <u>0</u>
☐ Cabenuva 400/600 mg Injection Kit	☐ 400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	☐ Maintenance dose: Inject 2 mL of cabotegravir and 2 mL of rilpivirine into the muscle every month	Quantity: 1 dosing kit Refills: _____
Dedicated Sunlenca Team Phone Number: 1-877-602-5889 Fax Number: 1-877-733-3199			
☐ Sunlenca	☐ 300 mg tablets ☐ 463.5 mg/1.5 mL vials	☐ Loading dose Option 1 927 mg by subcutaneous injection (2 x 1.5 mL injections) and 600 mg orally (2 x 300 mg tablets) on Day 1 Then 600 mg orally (2 x 300 mg tablets) on Day 2	☐ Loading dose 1 Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		☐ Loading dose Option 2 600 mg orally (2 x 300 mg tablets) on Day 1 600 mg orally (2 x 300 mg tablets) on Day 2 300 mg orally (1 x 300 mg tablet) on Day 8 Then 927 mg by subcutaneous injection (2 x 1.5 mL injections) on Day 15	☐ Loading dose 2 Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
		☐ Maintenance Dose 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection (+/-2 weeks).	☐ Maintenance Quantity: (1) Injection dosing kit (contains 2 vials) Refills: 1
☐ Trogarzo	N/A	Please complete a Trogarzo Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at https://www.trogarzo.com/hcp/patient-support/ or by calling 1-833-23-THERA (1-833-238-4372). Fax enrollment form to 1-855-836-3069.	N/A

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words " No Substitution " _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Patient Address: _____
 Prescriber Name: _____ Prescriber Phone: _____
 Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Yeztugo	☐ 300 mg tablets ☐ 463.5 mg/1.5 mL vials	☐ Loading dose: 300 mg tablets: Take 2 tablets by mouth on Day 1, then take 2 tablets by mouth on Day 2 Injection kit: Inject 927 mg (2 x 1.5 mL injections) subcutaneously on Day 1, then repeat every 6 months (26 weeks)	Quantity: ☐ (4) 300 mg tablets ☐ (1) Injection dosing kit (contains 2 vials) Refills: <u>0</u>
☐ Yeztugo	☐ 463.5 mg/1.5 mL vials	☐ Maintenance dose (Injection kit only): 927 mg (2 x 1.5 mL injections) subcutaneously every 6 months (26 weeks)	Quantity: ☐ (1) Injection dosing kit (contains 2 vials) Refills: _____

NRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cimduo	☐ 300/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Lamivudine/ Zidovudine* *Brand no longer available for this drug	☐ 150/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Descovy	☐ 200/25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Emtriva	☐ 200 mg	☐ _____	Quantity: _____ Refills: _____
☐ Epivir	☐ 150 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Abacavir/ Lamivudine* *Brand no longer available for this drug	☐ 600/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Retrovir	☐ 100 mg	☐ _____	Quantity: _____ Refills: _____
☐ Truvada	☐ 100/150 mg ☐ 133/200 mg ☐ 167/250 mg ☐ 200/300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Viread	☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Abacavir* *Brand no longer available for this drug	☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Zidovudine	☐ 100 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____

NNRTIs:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Edurant	☐ 25 mg	☐ _____	Quantity: _____ Refills: _____
☐ Efavirenz	☐ 600 mg	☐ _____	Quantity: _____ Refills: _____
☐ Intelence	☐ 25 mg ☐ 100 mg ☐ 200 mg	☐ _____	Quantity: _____ Refills: _____
☐ Pifeltro	☐ 100mg tablet	☐ Take once daily with or without food	Quantity: _____ Refills: _____
☐ Sustiva	☐ 50 mg ☐ 200 mg	☐ _____	Quantity: _____ Refills: _____
☐ Viramune	☐ 200 mg ☐ 50 mg/ 5 mL	☐ _____	Quantity: _____ Refills: _____
☐ Viramune XR	☐ 100 mg ☐ 400 mg	☐ _____	Quantity: _____ Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Patient Address: _____
 Prescriber Name: _____ Prescriber Phone: _____
 Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

Integrase Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Isentress	☐ 400 mg	☐ _____	Quantity: _____ Refills: _____
☐ Isentress HD	☐ 600 mg	☐ _____	Quantity: _____ Refills: _____
☐ Tivicay	☐ 50 mg	☐ _____	Quantity: _____ Refills: _____
☐ Tivicay PD	☐ 5 mg	☐ _____	Quantity: _____ Refills: _____
☐ Vocabria	N/A	All referrals must be sent through the HUB, ViiV Connect. Phone: 1-844-588-3288; Fax 1-844-208-7676	N/A

Entry Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Selzentry	☐ 150 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____

Protease Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aptivus	☐ 250 mg ☐ 100 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Eviator	☐ 300/150 mg	☐ _____	Quantity: _____ Refills: _____
☐ Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Fosamprenavir* *Brand no longer available for this drug	☐ 700 mg	☐ _____	Quantity: _____ Refills: _____
☐ Norvir	☐ 100 mg ☐ 80 mg/mL	☐ _____	Quantity: _____ Refills: _____
☐ Prezobix	☐ 800/150 mg	☐ _____	Quantity: _____ Refills: _____
☐ Prezista	☐ 75 mg ☐ 150 mg ☐ 600 mg ☐ 800 mg	☐ _____	Quantity: _____ Refills: _____
☐ Reyataz	☐ 150 mg ☐ 200 mg ☐ 300 mg	☐ _____	Quantity: _____ Refills: _____
☐ Viracept	☐ 250 mg ☐ 625 mg	☐ _____	Quantity: _____ Refills: _____

Attachment Inhibitors:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Rukobia	600 mg Extended-Release	☐ _____	Quantity: _____ Refills: _____

Pharmacokinetic Enhancer:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tybost	☐ 150 mg	☐ _____	Quantity: _____ Refills: _____

Metabolic Support:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Egrifta SV	N/A	Please complete an Egrifta SV Patient Enrollment and Consent Form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at https://hcp.egriftasv.com/ or by calling 1-833-23-THERA (1-833-238-4372). Fax enrollment form to 1-855-836-3069.	N/A
☐ Serostim	☐ _____	☐ _____	Quantity: _____ Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

HIV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment ____/____/____

5 PRESCRIPTION INFORMATION

Supportive Therapy:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Bactrim	☐ _____	☐ _____	Quantity: ____ Refills: ____
☐ Diflucan	☐ _____	☐ _____	Quantity: ____ Refills: ____
☐ Mytesi	125 mg tablet	☐ Take twice daily with or without food	Quantity: ____ Refills: ____

Other:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ _____	☐ _____	Quantity: ____ Refills: ____
☐ Other: _____	☐ _____	☐ _____	Quantity: ____ Refills: ____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Pharmacy, Inc. or one of its affiliates.