Gigi Specialty Pharmacy

A Dose Of Kindness
With Every Perscription.

Date Shipment Needed: _____ Ship To: ☐Patient ☐Physician ☐ Nursing needed ☐Training needed
► All the supplies including syringes and needles will be dispensed if needed.

HIV/AIDS Enrollment Form

Patient Name:	Physician Name:
Address:	State Lic # _____ DEA # _____
City: _____ State: ___ Zip: _____	NPI # _____ Specialty: _____
Home Phone: (___) ___ - ___	Practice Name/Hospital:
Work Phone: (___) ___ - ___	Address:
Cell Phone: (___) ___ - ___	City: _____ State: _____ Zip: _____
Patient Soc. Sec #: _____ Allergies: _____	Physician's Ph: (___) ___ - ___
Date of Birth: ___/___/___ Sex: ☐ Male ☐Female Weight: ___lbs ___kg	Physician's Fax: (___) ___ - ___
☐ See attached demographic sheet Height: BMI:	Nurse/Key Office Contact:

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance:	Secondary Insurance:	Rx Card (PBM):	Cardholder First Name:
City: _____ State: _____	City: _____ State: _____	PBM BIN:	Last Name:
Plan #:	Plan #:	City: _____ State: _____	Employer:
Group #:	Group #:	Group #:	ID #:
Phone: (___) ___ -	Phone: (___) ___ -	Phone: (___) ___ -	Group #:

DIAGNOSTIC INFORMATION

☐B20 ☐R64 ☐B18.2 ☐B18.1 ☐HIV-infected patients with abdominal lipodystrophy ☐ Other _____
CD4 count: _____, Viral Load /HIV RNA: _____, Hgb/Hct: _____, WBC/ ANC: _____, CrCl: _____ (Please include copy of the most recent labs)

STATEMENT OF MEDICAL NECESSITY

Has patient been on therapy before and relapsed? ☐Yes ☐No List of meds _____
Is patient currently on therapy? ☐Yes ☐No List of meds _____
Will any of the above medications be discontinued when patient starts on the new therapy? ☐Yes ☐No List of meds to be discontinued _____
(Note: Fuzeon must be taken as part of a combination antiviral regimen)
Is patient currently taking any other medications? ☐Yes ☐No List of medications _____
Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
Please Attach Script or fill in below: (one month supply will be dispensed unless quantity is indicated)

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Qty	Refill
NRTIs				
☐Emtriva				
☐Epivir				
☐Retrovir				
☐Videx				
☐Viread	300mg			
☐Zerit				
☐Ziagen				
NNRTIs				
☐Intelence	100mg			
☐Rescriptor				
☐Sustiva				
☐Viramune				
☐Edurant				
Combination Antiretrovirals				
☐Atripla	600/200/3000	1 tabpo daily (on an empty stomach)	30	
☐Combivir	150/300	1 tabpoBID (CrCl more than 50)	60	
☐Epzicom	600/300	1 tabpo daily (CrCl more than 50)	30	
☐Trizivir	300/150/300	1 tabpoBID (CrCl more than 50)	60	
☐Truvada	200/300	☐ 1 tabpo daily(CrCl more than 50) ☐ 1 tab po Q 48 hrs (CrC: 30-49)	30 15	
☐Stribild (Elvitegravir/Cobicistat/ Emtricitabine/Tenofovir)	150/150/200/300	☐ 1 tab po daily (CrCl: >70 mg/min)	30	
☐Complera (Rilpivirine/tenofovir/ emtricitabine)	25/300/200	☐ 1 tab po daily with a meal		
Fusion Inhibitors				
☐Fuzeon	90 mg vial	90 mg SQ BID (CrCl more than 35)		
☐Other _____				
☐Other _____				

Medication	Strength	Directions	Qty	Refill
Protease Inhibitors				
☐Aptivus				
☐Crixivan				
☐Invirase				
☐Kaletra				
☐Lexiva				
☐Norvir				
☐Prezista				
☐Reyataz				
☐Viracept				
Integrase Inhibitors/ CCR5 Inhibitors				
☐Isentress	400 mg	1 tabpoBID	60	
☐Tivicay				
☐Selzentry				
☐Other				
OTHER MEDICATIONS				
☐Bactrim				
☐Diflucan				
☐Procrit				
☐Neupogen				
☐Serostim	_____ OR *(Please call or go to www.itsrx.com to obtain a Serostim Referral Form)*			
☐Megace	40mg/ml			
☐Megace ES	625mg/5ml			
☐Egrifta	2 mg (2x1mg)	2 mg SQ daily	60 vial	

Physician Signature: _____ ☐DAW (Dispense As Written) **Date:** _____