Phone: 800-540-4700
Fax: 800-540-3400

To ePrescribe send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

HIV/AIDS ENROLLMENT FORM

____
____

340B Eligible Yes No

Ship to: ☐ Patient ☐ Physician
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ________________ DOB: __________________ ☐ Male ☐ Female SSN # ______________________

Patient's First Name: ______________________________ Patient's Last Name: ____________________________

Address: ______________________________ City: ______________________ State: _____ ZIP : _____________

Best Phone #: ______________________________ Alternate Phone # : ______________________________

Height: _______ Weight: ________ Emergency Contact: __________________ Allergies: ______________________

Insurance Information: Please fax copy of insurance card (front + back)

Primary Insurance: ____________________________________ Phone: ____________________________________

Policy #: ____ Group #: ____

Diagnosis and Clinical Informtion

Diagnosis (ICD -10 code) ________

☐ HIV/AIDS ☐ HBV ☐ HCV ☐ PrEP ☐ PEP
☐ Other

☐ CACHEXIA (HIV WASTING)

☐ Naïve to Treatment ☐ Experience to Treatment Therapy

Lab Value	Baseline	Current
CD4/T-Cell Count		
HIV/RNA		

Please forward a list of Current Medications

Prescriptions

Medication	Directions	Qty.	Refill
SINGLE TABLET REGIMENS			
☐ Atripla			
☐ Complera			
☐ Genvoya			
☐ Odefsey			
☐ Stribild			
☐ Triumeq			
PROTEASE INHIBITOR			
☐ Kaletra			
☐ Lexiva			
☐ Prezista			
☐ Reyataz			
☐ Viracept			
BOOSTED PROTEASE INHIBITOR			
☐ Evotaz			
☐ Prezocobix			
NNRTIS			
☐ Edurant			
☐ Intelence			
☐ Sustiva			
☐ Viramune XR			

Medication	Directions	Qty.	Refill
NRTIS			
☐ Combivir			
☐ Descovy			
☐ Emtriva			
☐ Epivir			
☐ Epzicom			
☐ Trizivir			
☐ Truvada			
☐ Ziagen			
INTEGRASE INHIBITORS			
☐ Isentress			
☐ Tivicay			
ENTRY INHIBITORS			
☐ Fuzeon			
☐ Selzentry			
PK ENHANCER			
☐ Tyboost			
OTHER			
☐ Bactrim			
☐ Egrifta			
☐ Serostim			
☐			

Prescriber Information

Physician Name (please print): ______________________________ Contact Name: ______________________________

NPI #: ____________________ DEA#: ____________________ Tax ID #: ______________________________

____

Office Address: ______________________________ City: ____________________ State: ______ ZIP: ______________

Phone #: ________________ Fax #: ________________ Email: ______________________________

O I authoirize Premier Pharmacy and it's representatives to act as an agent to initiate & execute prior authorization for above patient
In order to expedite the Prior Authorization process, please provide chart notes, most recent lab if non formulary medication.

Physician's Signature: ______________________________ DAW (Dispense as Written) **Date** ____/_____/_____

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