Infectious Disease Form
HIV-AIDS

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

Phone: 1-833-367-3278
Fax: 1-844-504-3278
Website: www.FOSRXFAST.com

Louisiana Office
2400 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M ☐ F ☐	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practitioner:		NPI:
Address:		
City		State/Zip
Office:		DEA:
Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION

Member Name:		M ☐ F ☐	DOB:
Address:		City:	
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:		BIN#:
PCN#:	Customer Service #:		Please attach a copy of the front and back of the patient's insurance card, if available.*****

PRESCRIPTION

New ☐ Refill ☐ Ship by: Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug	Strength
Single Tablet Regimens	
☐ Atripla®	☐ 600/200/300mg
☐ Biktarvy®	☐ 50/200/25mg
☐ Complera®	☐ 200/25/300mg
☐ Delstrigo®	☐ 100/300/300mg
☐ Genvoya®	☐ 150/150/200/10mg
☐ Juluca®	☐ 50/25mg
☐ Odefsey®	☐ 200/25/25mg
☐ Stribild®	☐ 150/150/200/300mg
☐ Symfi®	☐ 600/300/300mg
☐ Symfi Lo®	☐ 400/300/300mg
☐ Symtuza®	☐ 800/150/200/10mg
☐ Triumeq®	☐ 600/50/300mg
NRTI	
☐ Cimduo®	☐ 300/300mg
☐ Combivir®	☐ 150/300mg
☐ Descovy®	☐ 200/25mg
☐ Emtriva®	☐ 200mg
☐ Epivir®	☐ 150mg ☐ 300 mg
☐ Epzicom®	☐ 600/300mg
☐ Trizivir®	☐ 300/150/300mg
☐ Truvada®	☐ 200/300mg
☐ Viread®	☐ 150 ☐ 200 ☐ 250 ☐ 300
☐ Ziagen	☐ 300mg
☐ Zidovudine	☐ 100mg ☐ 300mg

Drug	Strength
Integrase Inhibitors	
☐ Insentress®	☐ 400mg
☐ Insentress HD®	☐ 600
☐ Tivicay®	☐ 10 ☐ 25 ☐ 50mg
Pharmacokinetic Enhancers	
☐ Norvir®	☐ 100mg
☐ Tybost®	☐ 150mg
Protease Inhibitors	
☐ Evotaz®	☐ 300/150mg
☐ Kaletra®	☐ 200/50mg ☐ 100/25mg
☐ Lexiva®	☐ 700mg
☐ Prezcobix®	☐ 800/150mg
☐ Prezista®	☐ 75 ☐ 150 ☐ 600 ☐ 800mg
☐ Reyataz®	☐ 50 ☐ 150 ☐ 200 ☐ 300mg
☐ Viracept®	☐ 250mg ☐ 625mg
NNRTI	
☐ Edurant®	☐ 25mg
☐ Intelence®	☐ 25 ☐ 100 ☐ 200mg
☐ Pifeltro®	☐ 100mg
☐ Sustiva®	☐ 50 ☐ 200 ☐ 600mg
☐ Viramune®	☐ 100mg ☐ 400mg
Entry Inhibitors	
☐ Fuzeon®	☐ 90mg vial
☐ Selzentry®	☐ 150mg ☐ 200mg
Other	
☐	

Directions	Qty	Refills

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

Diagnosis Description and ICD10:

☐ Patient is new to therapy ☐ Patient is currently on therapy

Prior Medication Failed: _____

Length of Treatment:_____

Reason for Discontinuation: _____

Is this medication for HIV prevention? Yes No if for prevention: PrEP PEP

Recent HIV/RNA: _____ Date: _____

Recebt CD4_____ cells/mm 3 Date: _____

HLA-B*5701 ☐ Present ☐ Reactive ☐ N/A

To assist with facilitating the prior authorization, pelase attach the following documents where appri-ate. Please indicate the documents attached:

☐ Failed Therapies ☐ Recent laboratory results ☐ CCR5/CXCR4 Tropism Assay
☐ Recent office notes ☐ Copy of front and back of insurance card

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	**Date:**