HIV ENROLLMENT FORM
Fax: 270-247-6033 or
270-251-3571

DUNCAN
SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066
Phone: 270-247-3725

Today's Date: Needs by Date: Ship to: ☐Patient ☐Office ☐Other:

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Home & Cell #:		DEA #:	State Lic#:
SSN:		NPI#:	
DOB:	Sex:	Phone:	Fax:
Patient Weight:	lbs or KG	Contact Person Name:	
Drug Allergies:		Contact E-mail:	

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic & Clinical Information

Diagnosis: ☐ B20HIV/AIDS ☐ B18.1 Chronic Hepatitis ☐ B18.2 Chronic Hepatitis C ☐ Other (include code):

Labs: CD/4/T-Cell: HIV RNA: HCV genotype: Viral Load:

(copies of IU/mL) ALT: Liver Biopsy Results: Hgb/Hct: WBC: Test Date:

Prescription Information

	DOSE & DIRECTIONS	QTY	REFILLS
NRTIs/NNRTIs			
Descovy			
Edurant			
Emtriva			
Epivir			
Intelence			
Retrovir			
Sustiva			
Videx			
Viread			
Viramune			
Zerit			
Ziagen			
Protease Inhibitors			
Aptivus			
Crixivan			
Evotaz			
Invirase			
Kaletra			
Lexiva			
Norvir			
Prezista			
Prezcobix			
Reyataz			
Viracept			
Entry Inhibitors			
Fuzeon			
Selzentry			
Other			

	DOSE & DIRECTIONS	QTY	REFILLS
Combination Antiretroviral			
Atripla			
Combivir			
Complera			
Epzicom			
Genvoya			
Odesfey			
Stribild			
Triumeq			
Trizivir			
Truvada			
Integrase Inhibitor/CCRS			
Isentress			
Selzentry			
Tivicay			
Vitekta			
TAF			
Genvoya			
Other Medications			
Bactrim SS or DS			
Dapsone			
Diflucan			
Ethambutol			
Famvir			
Mepron Suspension			
Procrit			
Tybost			
Valtrex			
Zithromax			
Zovirax			

Prescriber Signature: _____ Date: _____