OPTUM®

Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

HIV Enrollment Form

Specialty Pharmacy Enrollment Form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona**

PATIENT INFORMATION

Patient Name _____
Address _____
City, State, Zip _____
Preferred phone number _____ Alternate Phone _____
DOB _____ Gender _____
Language Preference: ☐English ☐Spanish ☐Other _____
Allergies/Comments _____
Concomitant Medications _____
Weight _____kg/lbs Height _____cm/in

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number: _____

DIAGNOSTIC/CLINICAL INFORMATION | *Please fax recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____
CD4 Count: _____ Viral Load: _____ Date of Labs: _____

PrEP: ☐ Yes ☐ No

Hep B test compleed? ☐ Yes ☐ No
Hep C test completed? ☐ Yes ☐ No
HLA-B*5701 test completed? ☐ Yes ☐ No

☐ Naïve to Treatment Therapy
☐ Experienced to Treatment Therapy

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
☐ Biktarvy	☐ 50/200/25 mg tablet			
☐ Cimduo	☐ 300/300 mg tablet			
☐ Descovy	☐ 200/25 mg tablet			
☐ Dovato	☐ 50/300 mg tablet			
☐ Epzicom	☐ 600/300 mg tablet			
☐ Genvoya	☐ 150/150/200/10 mg tablet			
☐ Intelence	☐ 25 mg tablet ☐ 100 mg tablet ☐ 200 mg tablet			
☐ Isentress	☐ 25 mg chewable tablet ☐ 100 mg chewable tablet ☐ 100 mg granules for suspension ☐ 400 mg tablet			
☐ Isentress HD	☐ 600 mg tablet			
☐ Juluca	☐ 50/25 mg tablet			
☐ Norvir	☐ 100 mg tablet ☐ 100 mg powder ☐ 80 mg/mL solution			

Medication	Dose/Strength	Directions	Qty	Refills
☐ Odefsey	☐ 200/25/25 mg tablet			
☐ Prezcobix	☐ 800/150 mg tablet			
☐ Prezista	☐ 75 mg tablet ☐ 150 mg tablet ☐ 600 mg tablet ☐ 800 mg tablet ☐ 100 mg/mL suspension			
☐ Reyataz	☐ 150 mg capsule ☐ 200 mg capsule ☐ 300 mg capsule ☐ 50 mg oral powder			
☐ Symtuza	☐ 800/150/200/10 mg tablet			
☐ Tivicay	☐ 10 mg tablet ☐ 25 mg tablet ☐ 50 mg tablet			
☐ Triumeq	☐ 600/50/300 mg tablet			
☐ Truvada	☐ 100/150 mg tablet ☐ 133/200 mg tablet ☐ 167/250 mg tablet ☐ 200/300 mg tablet			
☐				
☐				

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

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐Product Substitution permitted ☐Dispense as Written

Prescriber's Signature _____ Date: _____ Supervising Physician Signature: _____ Date: _____
Electronic or digital signatures not accepted.