HIV / AIDS

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Male/Female:	
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete and Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity **Date:**

☐ 042 HIV / AIDS ☐ 799.4 Cachexia (HIV Wasting) ☐ 070.54 Hepatitis C (chronic) ☐ 070.32 Hepatitis B ☐ Other:_____

CD4 count: _____ Viral Load/HIV RNA:_____ Hgb/Hct:_____ WBC/ANC:_____ CrCl:_____ (Please include copy of the most recent labs)

Has patient been on therapy before and relapsed? ___Y ___N List of Meds:_____

Is patient currently on therapy? ___Y ___N List of Meds:_____

Will any of the above medications be discontinued when patient starts on the new therapy? ___Y ___N

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? ___Y ___N List of Meds:_____

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

Medication	Strength	Directions	Q	R
NRTIs				
☐ Emtriva				
☐ Epivir				
☐ Retrovir				
☐ Videx				
☐ Viread	300mg			
☐ Zerit				
☐ Ziagen				
NNRTIs				
☐ Intelence	100mg			
☐ Sustiva				
☐ Viramune				
Combination Antiretrovirals				
☐ Atripla	600/200/3000	1 tab po daily (on an empty stomach)	30	
☐ Combivir	150/300	1 tab po BID (CrCl more than 50)	60	
☐ Epzicom	600/300	1 tab po daily (CrCl more than 50)	30	
☐ Trizivir	300/150/300	1 tab po BID (CrCl more than 50)	60	
☐ Truvada	200/300	☐ 1 tab po daily (CrCl more than 50)	30	
		☐ 1 tab po Q 48 hrs (CrC: 30-49)	15	
Fusion Inhibitors				
☐ Fuzeon	90 mg vial	90 mg SQ BID (CrCl more than 35)	30	
☐ Other				

Medication	Strength	Directions	Qty	Refill
Protease Inhibitors				
☐ Aptivus				
☐ Crixivan				
☐ Invirase				
☐ Kaletra				
☐ Lexiva				
☐ Norvir				
☐ Prezista				
☐ Reyataz				
☐ Viracept				
Integrase Inhibitors/ CCR5 Inhibitors				
☐ Isentress	400mg	1 tab po BID	60	
☐ Selzentry				
☐ Other				
Other Medications				
☐ Bactrim				
☐ Diflucan				
☐ Procrit				
☐ Neupogen				
☐ Megace	40mg/ml			
☐ Megace ES	625mg/5ml			
☐ Other				

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested.*

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient Signature:_____ Date:_____