



HIV / AIDS ENROLLMENT / PRESCRIPTION FORM

Customer Service Phone 1-800-850-9122

Fax to 1-800-218-3221

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Shipping Address (if different from home address) <input type="checkbox"/> Ship to MD		Home Phone Number ()	Work Phone Number ()

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Start Date _____ Weight _____ lbs kg Current BMI _____
 HIV-1 viral load _____ CD4+Lymphocyte count _____
 HCV HBV Depression Cardiac Disease Diabetes Other _____ See Attached
 HIV-1 virus resistant to at least one Protease Inhibitor Yes No Name of Protease Inhibitor _____
 Current antiretroviral medication _____
 Other Medications _____ See Attached
 Allergies _____ NKDA

PRESCRIPTION INFORMATION

Serostim [®] [somatropin (rDNA origin) for injection]		
_____ inject 4mg subcutaneously per day for 28 days.	_____ SeroJet	
_____ inject 5mg subcutaneously per day for 28 days.		
_____ inject 6mg subcutaneously per day for 28 days.	Quantity _____	Refill x _____
Directions _____		
Fuzeon [®] (efuvirtide)		
_____ inject 90mg (1ml) subcutaneously twice daily	Quantity _____	Refill x _____

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address	City	State	Zip
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge. Physician's Signature _____	NPI
			DEA

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist.

For refills, please call-in or fax 7 days in advance of next appointment.

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