

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE - FIRST DOSE OFFICE - ALL DOSES OTHER _____

PATIENT INFORMATION		
Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	Date of Birth
Social Security #	Sex	
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other:	
Gender Identity		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> other:		

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant		
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone		Fax
Contact Person		Preferred Method of Contact
		<input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD(S)

CLINICAL INFORMATION		
Patient Height:	Patient Weight:	Patient Allergies:
Diagnosis / ICD10: <input type="checkbox"/> B20 HIV <input type="checkbox"/> Z20.6 PrEP <input type="checkbox"/> Other: _____ DX Code: _____ <input type="checkbox"/> Other: _____ DX Code: _____		
Date of Diagnosis: _____ Viral Load: _____ Date: _____ CD4 Count: _____ Date: _____ Serum Creatinine: _____ Date: _____		
Is patient naive to therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list previous treatment and reason for discontinuation: _____		
PrEP <input type="checkbox"/> Yes <input type="checkbox"/> No PEP <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Negative HIV Test: _____ Serum Creatinine: _____ History of Osteopenia/Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous treatment and reason for discontinuation: _____		

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Dispense As Written (no stamps) _____ **Date** _____ **Substitution Permitted** (no stamps) _____ **Date** _____

- In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
- By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
- The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
- Prescribers must comply with any of their state-specific prescription requirements.

PRESCRIBER INFORMATION

Prescriber Name		Address		
Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant		City	State	ZIP
Supervising Physician (If prescriber is a NP or PA)		Phone		Fax
DEA #	NPI #	Tax ID#	Contact Person	

PATIENT INFORMATION

Patient Name	Date of Birth
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PRESCRIPTION INFORMATION			QTY	REFILLS
<input type="checkbox"/> Atripla	600/200/300 mg	Take 1 tablet by mouth daily on empty stomach (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Biktarvy	50/200/25 mg	Take 1 tablet by mouth daily (CrCl ≥30 mL/min)	_____	_____
<input type="checkbox"/> Cimduo	300/300 mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Delstrigo	100/300/300 mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Descovy	200/25 mg	Take 1 tablet by mouth daily (CrCl ≥30 mL/min)	_____	_____
<input type="checkbox"/> Dovato	50/300 mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min) **	_____	_____
<input type="checkbox"/> Edurant	25 mg	Take 1 tablet by mouth daily with food **	_____	_____
<input type="checkbox"/> Emtriva	200 mg	Take 1 capsule by mouth daily **	_____	_____
<input type="checkbox"/> Epzicom	600/300 mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Evotaz	300/150 mg	Take 1 tablet by mouth daily with food **	_____	_____
<input type="checkbox"/> Genvoya	150/150/200/10 mg	Take 1 tablet by mouth daily with food (CrCl ≥30 mL/min)	_____	_____
<input type="checkbox"/> Intelence	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg		_____	_____
<input type="checkbox"/> Isentress	<input type="checkbox"/> 25 mg chewable tablet - pediatric <input type="checkbox"/> 100 mg chewable tablet - pediatric <input type="checkbox"/> 100 mg granules for suspension - pediatric <input type="checkbox"/> 400 mg tablet		_____	_____
<input type="checkbox"/> Isentress HD	600 mg tablet	Take 2 tablets by mouth once a day **	_____	_____
<input type="checkbox"/> Juluca	50/25 mg	Take 1 tablet by mouth daily with food **	_____	_____
<input type="checkbox"/> Norvir	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 100 mg powder <input type="checkbox"/> 80 mg/mL solution		_____	_____
<input type="checkbox"/> Odefsey	200/25/25 mg	Take 1 tablet by mouth daily with food (CrCl ≥30 mL/min) **	_____	_____
<input type="checkbox"/> Pifeltro	100 mg	Take 1 tablet by mouth daily	_____	_____
<input type="checkbox"/> Prezcobix	800-150 mg	Take 1 tablet by mouth daily with food **	_____	_____
<input type="checkbox"/> Prezista	<input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg <input type="checkbox"/> 100 mg/mL suspension		_____	_____
<input type="checkbox"/> Reyataz	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 50 mg oral powder		_____	_____
<input type="checkbox"/> Selzentry	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 20 mg/mL solution		_____	_____
<input type="checkbox"/> Symfi	600/300/300 mg	Take 1 tablet by mouth daily on empty stomach (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Symfi Lo	400/300/300 mg	Take 1 tablet by mouth daily on empty stomach (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Symtuza	800/150/200/10 mg	Take 1 tablet by mouth daily with food (CrCl ≥30 mL/min)	_____	_____
<input type="checkbox"/> Tivicay	<input type="checkbox"/> 10 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg		_____	_____
<input type="checkbox"/> Triumeq	600/50/300 mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
<input type="checkbox"/> Truvada	200/300 mg	Take 1 tablet by mouth daily **	_____	_____
<input type="checkbox"/>			_____	_____
<input type="checkbox"/>			_____	_____
<input type="checkbox"/>			_____	_____

In order to expedite the prior authorization process, please fax copies of the patient's most recent progress notes and lab work.

** Dosing adjustments may be necessary based on certain labs and clinical guidelines

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