Infectious Disease

Select Location

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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 ❑ Male ❑ Female ❑ other:	
Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ other:		

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type ❑ Physician (MD or DO) ❑ Nurse Practitioner ❑ 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 ❑ Phone ❑ Fax ❑ Email	

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

CLINICAL INFORMATION

Patient Height:	Patient Weight:	Patient Allergies:

Diagnosis / ICD10: ❑ B20 HIV ❑ Z20.6 PrEP ❑ Other:_____ DX Code: _____ ❑ Other:_____ DX Code:_____

Date of Diagnosis: _____ Viral Load: _____ Date: _____ CD4 Count: _____ Date: _____ Serum Creatinine: _____ Date: _____

Is patient naive to therapy: ❑ Yes ❑ No If no, list previous treatment and reason for discontinuation:_____

PrEP ❑ Yes ❑ No **PEP** ❑ Yes ❑ No Date of Negative HIV Test:_____ Serum Creatinine:_____ History of Osteopenia/Osteoporosis ❑ Yes ❑ No

Previous treatment and reason for discontinuation: _____

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

1. 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.
2. 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.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.

PRESCRIBER INFORMATION

Prescriber Name		Address	
Prescriber Type ❑ Physician (MD or DO) ❑ Nurse Practitioner ❑ 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

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

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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