Infectious Disease

Select Location

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: _____

INJECTABLE PRE-EXPOSURE PROPHYLAXIS (PrEP) PRESCRIPTION INFORMATION				QTY	REFILLS
❑ Apretude **PrEP Only*	**Optional Oral Lead In** **Injection**	❑ Cabotegravir 30mg tab ❑ 600mg (3-mL) injection	Optional Oral Lead In Needed: ❑ Yes ❑ No **Month 1 & 2**: 1 injection IM **Month 4 & continuation**: 1 injection IM, every 2 months	_____ _____	_____ _____
❑ Yeztugo **PrEP Only*	**Mandatory Initiation Dose** **Injection**	❑ Yeztugo Oral 300mg tab ❑ Yeztugo 927mg SubQ	Take 2 tablets (600mg) by mouth on day 1, then 2 tablets on day 2 Inject 2 x 1.5 mL's subcutaneously on day 1, then repeat every 6 months	4 2 x 1.5 mL Syringe	0 _____
❑ Yeztugo **Oral Bridge Only *Only for planned missed injections.*	❑ Yeztugo Oral 300mg tab		Take 1 tablet by mouth once every 7 days, as directed, for up to 6 months	4	_____

HIV (HUMAN IMMUNODEFICIENCY VIRUS) PRESCRIPTION INFORMATION			QTY	REFILLS
❑ Atripla	600/200/300mg	Take 1 tablet by mouth daily on empty stomach (CrCl ≥50 mL/min)	_____	_____
❑ Biktarvy	50/200/25mg	Take 1 tablet by mouth daily (CrCl ≥30 mL/min)	_____	_____
❑ Cabenuva **Once Monthly Dosing*	**Optional Oral Lead In** ❑ Cabotegravir 30mg tab ❑ Rilpivirine 25mg tab **Injection** ❑ 600mg/900mg kit ❑ 400mg/600mg kit	Optional Oral Lead In Needed: ❑ Yes ❑ No Please complete ViivVenrollment form if utilizing the OLI **Month 1**: 2 injections (600mg/900mg) IM **Month 2 & continuation**: 2 injections (400mg/600mg) IM, every month	1 dosing kit 1 dosing kit	0 _____
❑ Cabenuva **Every 2 Month Dosing*	**Optional Oral Lead In** ❑ Cabotegravir 30mg tab ❑ Rilpivirine 25mg tab **Injection** ❑ 600mg/900mg kit	Optional Oral Lead In Needed: ❑ Yes ❑ No Please complete ViiV enrollment form if utilizing the OLI **Month 1 & 2**: 2 injections IM **Month 4 & continuation**: 2 injections IM, every 2 months	1 dosing kit 1 dosing kit	_____ _____
❑ Cimduo	300/300mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
❑ Delstrigo	100/300/300mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min)	_____	_____
❑ Descovy	200/25mg	Take 1 tablet by mouth daily (CrCl ≥30 mL/min)	_____	_____
❑ Dovato	50/300mg	Take 1 tablet by mouth daily (CrCl ≥50 mL/min) **	_____	_____
❑ Edurant	25mg	Take 1 tablet by mouth daily with food **	_____	_____

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*

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.

Infectious Disease

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

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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.