

For assistance, contact your pharmacy representative: \_\_\_\_\_ Phone: \_\_\_\_\_ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Pharmacy: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Date Needed: \_\_\_\_\_ Ship To:  Prescriber's Office  Patient's Home  Other: \_\_\_\_\_

**PATIENT INFORMATION**

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
Insurance provider (Please include copy of front and back of card): \_\_\_\_\_  
ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  Patient is eligible for Medicare

**CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription**

Is this medication for HIV prevention?  Yes  No If for prevention:  PrEP  PEP  Patient is new to therapy  Patient is currently on therapy Start date: \_\_\_\_\_  
ICD-10 code: \_\_\_\_\_ ICD-10 description: \_\_\_\_\_  
Recent HIV RNA: \_\_\_\_\_ Date: \_\_\_\_\_ Recent CD4: \_\_\_\_\_ cells/mm<sup>3</sup> Date: \_\_\_\_\_  
HLA-B\*5701  Present  Reactive  N/A Allergies: \_\_\_\_\_  
To assist with facilitating the prior authorization, please attach the following documents where appropriate. Please indicate the document(s) attached:  
 Failed therapies  Recent laboratory results  CCR5/CXCR4 Tropism Assay  Recent office notes  Copy of front and back of insurance card

**Single Tablet Regimens**

Atripla 600/200/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Biktarvy 50/200/25mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Complera 200/25/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Delstrigo 100/300/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Dovato 50/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Genvoia 150/150/200/10mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Juluca 50/25mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Odefsey 200/25/25mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Stribild 150/150/200/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Symfi 600/300/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Symfi Lo 400/300/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Symtuza 800/150/200/10mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Triumeq 600/50/300mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**Integrase Inhibitors**

Isentress 400mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Isentress HD 600mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Tivicay  10mg  25mg  50mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**Pharmacokinetic Enhancers**

Norvir 100mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Tybost 150mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**Protease Inhibitors**

Evotaz 300/150mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Kaletra  200/50mg  100/25mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Lexiva 700mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_  
 Prezobix 800/150mg  
Directions: \_\_\_\_\_ Qty \_\_\_\_\_ Refills \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's name: \_\_\_\_\_ Practice/facility: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Office contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Best time to call: \_\_\_\_\_ Preferred method of contact:  Email  Phone  Fax  
State license #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Drug names are the property of their respective owners.