For assistance, contact your pharmacy representative: ______________________ Phone: ______________________ **(For providers only)**
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)**.

HIV Prevention
Prescription/Pharmacy Intake Form

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: ☐Preexposure Prophylaxis (PrEP) **OR** ☐Postexposure Prophylaxis (PEP)? Start date: ______________

ICD-10 code: ______________ ICD-10 description: ______________________

To assist with facilitating the prior authorization, please attach the following documents where appropriate. Please indicate the documents(s) attached: ☐Recent office notes ☐Copy of front and back of insurance card

PrEP Medications

☐Apretude Injection Kit 600mg

Directions: ______________________ Qty ________ Refills ______

☐Descovy 200/25mg

Directions: ______________________ Qty ________ Refills ______

☐Truvada 200/300mg

Directions: ______________________ Qty ________ Refills ______

PEP Medications

PEP Consultation Service for Clinicians: 1-888-448-4911 (9 a.m. – 2 a.m. ET)

Preferred Therapy

☐Truvada 200/300mg PO daily AND Isentress 400mg PO twice daily x28 days

☐Truvada 200/300mg PO daily AND Tivicay 50mg PO daily x 28 days

Alternative Therapy

☐Truvada 200/300mg PO daily AND Prezista 800mg PO daily AND Norvir 100mg PO daily x28 days

☐ ______________________

Directions: ______________________ Qty ________ Refills ______

☐ ______________________

Directions: ______________________ Qty ________ Refills ______

Note: Other regimens may be used in pregnancy, pediatrics, or renal impairment.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: ______________ State: ________ Zip code: ______________

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.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.
Drug names are the property of their respective owners.

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