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 Treatment and 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 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^3 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 documents(s) attached:
☐Failed therapies ☐Recent laboratory results ☐CCR5/CXCR4 Tropism Assay ☐Recent office notes ☐Copy of front and back of insurance card

Long Acting PrEP
☐Apretude Injection Kit 600mg
Directions: ______________ ____ Qty ____ Refills

Long Acting Injectable Therapy
☐Cabenuva 600mg/900mg Kit (first month, after completing oral lead in therapy)
Directions: ______________ ____ Qty ____ Refills
☐Cabenuva 400mg/600mg Kit (on going injections)
Directions: ______________ ____ Qty ____ Refills

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
☐Genvoya 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
☐Prezcobix 800/150mg
Directions: ______________ ____ Qty ____ Refills
☐Prezista ☐75mg ☐150mg ☐600mg ☐800mg
Directions: ______________ ____ Qty ____ Refills
☐Reyataz ☐50mg ☐150mg ☐200mg ☐300mg
Directions: ______________ ____ Qty ____ Refills
☐Viracept ☐250mg ☐625mg
Directions: ______________ ____ Qty ____ Refills

NNRTI
☐Edurant 25mg
Directions: ______________ ____ Qty ____ Refills
☐Intelence ☐25mg ☐100mg ☐200mg
Directions: ______________ ____ Qty ____ Refills
☐Pifeltro 100mg
Directions: ______________ ____ Qty ____ Refills
☐Sustiva ☐50mg ☐200mg ☐600mg
Directions: ______________ ____ Qty ____ Refills
☐Viramune XR ☐100mg ☐400mg
Directions: ______________ ____ Qty ____ Refills

NRTI
☐Cimduo 300/300mg
Directions: ______________ ____ Qty ____ Refills
☐Combivir 150/300mg
Directions: ______________ ____ Qty ____ Refills
☐Descovy 200/25mg
Directions: ______________ ____ Qty ____ Refills
☐Emtriva 200mg
Directions: ______________ ____ Qty ____ Refills
☐Epivir ☐150mg ☐300mg
Directions: ______________ ____ Qty ____ Refills
☐Epzicom 600/300mg
Directions: ______________ ____ Qty ____ Refills
☐Trizivir 300/150/300mg
Directions: ______________ ____ Qty ____ Refills
☐Truvada 200/300mg
Directions: ______________ ____ Qty ____ Refills
☐Viread ☐150mg ☐200mg ☐250mg ☐300mg
Directions: ______________ ____ Qty ____ Refills
☐Ziagen 300mg
Directions: ______________ ____ Qty ____ Refills
☐Zidovudine ☐100mg ☐300mg
Directions: ______________ ____ Qty ____ Refills

Entry Inhibitors
☐Fuzeon 90mg vial
Directions: ______________ ____ Qty ____ Refills
☐Selzentry ☐150mg ☐300mg
Directions: ______________ ____ Qty ____ Refills

Other
☐ ______________________
Directions: ______________ ____ Qty ____ Refills

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.

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Drug names are the property of their respective owners.
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