

HIV

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender:	Female Male
Email:		Allergies:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Phone:	Policy #:	Group #:
Secondary Insurance:	Phone:	Policy #:	Group #:

CLINICAL INFORMATION

Diagnosis:	ICD-10:	Serum Creatinine:
CD4 Count:	Viral Load:	Date of Labs:
☐ Treatment Naïve ☐ Treatment Experienced		Prior Treatment Type:

Comorbidities: Allergies ☐ NKDA ☐ Other _____

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS	MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
APRETUDE [®] (cabotegravir)	☐ 600 mg/vial	Inject 1 dosing kit IM on Month 1 & 2 then every 2 months thereafter	1 dosing kit		ODEFSEY [®] (emtricitabine, rilpivirine, and tenofovir alafenamide)	☐ 200/25/25 mg tablet	One tablet PO daily with food	30 tablets	
ATRIPLA [®] (efavirenz, emtricitabine, tenofovir disoproxil fumarate)	☐ 600 mg ☐ 300 mg ☐ 200 mg	One tablet PO daily on an empty stomach	30 tablets		PIFELTRO [™] (doravirine)	☐ 100 mg tablet	One tablet PO daily with food	30 tablets	
BIKTARVY [®] (bictegravir, emtricitabine, tenofovir alafenamide)	☐ 50 mg ☐ 200 mg ☐ 25 mg	One tablet PO Use daily			PREZCOBIX [®] (darunavir and cobicistat)	☐ 800/150 mg tablet	One tablet PO Use daily	30 tablets	
CABENUVA (amivudine, zidovudine)	☐ 400 mg/ 600 mg/vial ☐ 300 mg/ 900 mg/vial	Inject 1 dosing kit IM on Month 1 & 2 then every _____ months thereafter	1 dosing kit		PREZISTA [®] (darunavir)	☐ 75 mg tablet ☐ 150 mg tablet ☐ 600 mg tablet ☐ 800 mg tablet ☐ 100 mg/mL suspension	Take _____ times a day	1 month supply	
COMBIVIR [®] (lamivudine, zidovudine)	☐ 50 mg/ 300 mg	One tablet PO Use 2 times a day (every 12 hours)	60 tablets		RUKOBIA [®] (fostemsavir)	☐ 60 mg tablet	One tablet PO 2 times a day		
COMPLERA [®] (emtricitabine, rilpivirine, tenofovir disoproxil fumarate)	☐ 20 mg/25 mg/ 300 mg	One tablet PO daily with food	1 month supply		REYATAZ [®] (atazanavir sulfate)	☐ 100 mg ☐ 150 mg ☐ 200 mg ☐ 300 mg	Take _____ tablet _____ times a day	1 month supply	
DESUBQVY [®] (emtricitabine, tenofovir alafenamide)	☐ 200 mg/ 25 mg	One capsule PO daily			SELZENTRY [®] (maraviroc)	☐ _____ mg tablet	Take _____ tablet _____ times a day	1 month supply	
DOVATO [®] (dolutegravir, lamivudine)	☐ 50 mg/ 300 mg	One tablet PO daily	30 tablets		STRIBILD [®] (elvitegravir, cobicistat, emtricitabine, tenofovir disoproxil fumarate)	☐ 150/ 150/ 200/ 300 mg tablet	One tablet PO daily with food	1 month supply	
EDURANTA [®] (rilpivirine)	☐ 25 mg tablet	Take _____ tablet PO daily with food			SUSTIVA [®] (efavirenz)	☐ 600 mg tablet	Take one tablet at bedtime	30 tablets	
EGRIFTA [™] (tesamorelin)	☐ 2 mg vial	Inject 1.4 mg SUBQ once daily	30 days supply	11	TIVICAY [®] (dolutegravir)	☐ 50 mg tablet	Take _____ tablet _____ times a day	1 month supply	
EMTRIVA [®] (emtricitabine)	☐ 200 mg caps	One capsule PO daily	30 capsules		TRIUQUE [®] (abacavir, dolutegravir, lamivudine)	☐ 50/600/300 mg tablet	One tablet PO daily with or without food	30 tablets	
EPIVIR [®] (lamivudine)	☐ 150 mg caps ☐ 300 mg caps	One capsule _____ x daily	1 month supply		TRIZIVIR [®] (abacavir, lamivudine, zidovudine)	☐ 300/150/300 mg tablet	One tablet PO 2 times a day	60 tablets	
EPZICOM [®] (abacavir, lamivudine)	☐ 600 mg/ 300 mg tablet	One tablet PO daily	1 month supply		TROGARZO [™] (ibalizumab-uiyk)	☐ 150 mg/ mL	☐ Induction Dose: 2000 mg IV dose per 250 mL Sodium Chloride 0.9% ☐ Maintenance Dose: 800 mg IV per 250 mL Sodium Chloride 0.9% every 14 days		
EVOTAZ [™] (atazanavir, cobicistat)	☐ 300 mg/150 mg tablet	One tablet PO daily with food	30 tablets		TRUVADA [®] (emtricitabine and tenofovir disoproxil fumarate)	☐ 200/ 300 mg tablet	One tablet PO daily with or without food		
FUZEON [®] (enfuvirtide)	☐ 108 mg/vial	Inject 90 mg SUBQ 2 times a day	1 kit		VIRACEPT [®] (nelfinavir mesylate)	☐ 250 mg ☐ 625 mg	Take _____ tablet 3 times a day		
GENVOYA [®] (elvitegravir, cobicistat, emtricitabine, tenofovir alafenamide)	☐ 150/150/200/10 tablet	One tablet PO daily with food	30 tablets		VIRAMUNE XR [®] (nevirapine)	☐ 400 mg tablet	One tablet PO daily		
INTELENCE [®] (etravirine)	☐ 200 mg tablet	One tablet PO 2 times a day	1 month supply		VIREAD [®] (tenofovir disoproxil fumarate)	☐ 300 mg tablet	Take _____ tablet daily		
ISENTRESS [®] (raltegravir)	☐ 400 mg tablet	One tablet PO 2 times a day	60 tablets		ZERIT [®] (stavudine)	☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg	Take _____ tablet 2 times a day		
KALETRA [®] (lopinavir/ritonavir)	☐ 200/ 50 mg tablet	Take _____ tablet _____ times a day	120 tablets		☐ OTHER				
LEXIVA [®] (fosamprenavir calcium)	☐ 700 mg tablet	Take _____ tablet _____ times a day	1 month supply		☐ OTHER				
NORVIR [®] (ritonavir)	☐ 100 mg tablet	Take _____ tablet _____ times a day	1 month supply						

Start of Therapy Date: Ship To: ☐ Patient ☐ MD Office

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State: ZIP:
NPI #:	Tax ID #:	
Prescriber Signature:	Date:	