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)**.

Walgreens | allianceRx Walgreens Pharmacy

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

☐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

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *****