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)**.

allianceRx Walgreens Pharmacy

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 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

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