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 + PRIME

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

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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