PEP Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐Male ☐Female Weight_____ ☐lbs. ☐kg
Height: _____ ☐in ☐cm Known Allergies_____
Preferred Phone: _____
Address: _____ City: _____ State_____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: _____ NPI#_____ Tax ID#_____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____

3. Diagnosis/Clinical Information

CrCl: _____Date:_____
Pregnancy:_____Date:_____
TB Testing:_____Date: _____
HLA-B*5701 Testing:_____Date:_____
STI Testing: ☐ Yes ☐ No
Results: ☐ None Positive (Record positive results below)

HIV RNA: _____Date:_____
CD4 Count: _____ **Date**: _____
Resistance Testing: ☐ Yes ☐ No
Results: _____
HCV Coinfection: ☐ Yes ☐ No
HBV Coinfection: ☐ Yes ☐ No
HBV Status: _____

Concurrent Medications:

Medication	Dosing	Indication	Plan
			☐Continue ☐Stop ☐Change: _____
			☐Continue ☐Stop ☐Change: _____
			☐Continue ☐Stop ☐Change: _____
			☐Continue ☐Stop ☐Change: _____
			☐Continue ☐Stop ☐Change: _____

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
Preferred Regimens				
☐ Truvada ® PLUS Isentress ® ☐ (Tenofovir disoproxil fumarate-emtricitabine PLUS Raltegravir)	☐ Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg tablet ☐ Raltegravir: 400 mg tablet ☐ Raltegravir: 600 mg tablet	☐ Truvada once daily for 28 days initiated therapy within 72 hours of exposure ☐ PLUS ☐ Raltegravir 400 mg twice daily		
☐ Truvada® PLUS Tivicay® ☐ (Tenofovir disoproxil fumarate-emtricitabine PLUS Dolutegravir)	☐ Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg tablet ☐ Dolutegravir: 10 mg tablet ☐ Dolutegravir: 25 mg tablet ☐ Dolutegravir: 50 mg tablet	☐ Truvada once daily for 28 days initiated therapy within 72 hours of exposure ☐ PLUS ☐ Dolutegravir 50 mg once daily		

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PEP Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

Medication	Dose/Strength	Sig	QTY.	Refills
Alternative Regimens				
☐ Stribild ☐ (Elvitegravir-cobicistat-emtricitabine-tenofovir disoproxil fumarate)	☐ Elvitegravir 150 mg, cobicistat 150 mg, emtricitabine 200 mg, and tenofovir disoproxil fumarate 300 mg	☐ One tablet once daily		
☐ Truvada® PLUS Prezista® WITH ritonavir ☐ (Tenofovir disoproxil fumarate-emtricitabine PLUS darunavir WITH ritonavir)	☐ Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg tablet ☐ Darunavir: 800 mg tablet ☐ Ritonavir: 100 mg tablet	☐ Truvada once daily for 28 days initiated therapy within 72 hours of exposure ☐ Prezista 800 mg plus ritonavir 100 mg once daily		
☐ Complera® ☐ Rilpivirine emtricitabine-tenofovir disoproxil fumarate	☐ Emtricitabine 200 mg, rilpivirine 25 mg, and tenofovir disoproxil fumarate 300 mg	☐ One tablet once daily		

Dispensing Options: ☐Patient ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below	
Dispense as Written Date	Substitution Permitted Date

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.