



## HIV

**Patient Information:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Gender: M F Caregiver: \_\_\_\_\_

**Prescriber Information:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax ID: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**CLINICAL INFORMATION:**  B20 Human Immunodeficiency Virus (HIV) Disease  Z20.6 Contact with and (suspected) exposure to HIV  
 Other (ICD-10 Code): \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

CD4 Count: \_\_\_\_\_ Viral Load: \_\_\_\_\_ Date of Labs: \_\_\_\_\_

Naïve to Treatment Therapy  Experienced to Treatment Therapy  
 Hepatitis B Test Completed?  Yes  No  HLA-B\*5701 Test Completed?  Yes  No  
 Hepatitis C Test Completed?  Yes  No

**PLEASE FAX COPIES:**  Medical Card (Front and Back)  Prescription Card (Front and Back)  Clinical Notes

Medication	Dosage & Strength*	Directions*	Quantity	Medication	Dosage & Strength*	Directions*	Quantity
<b>Single Tablet Regimens</b>				<b>Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)</b>			
<input type="checkbox"/> <b>Atripla</b>	600-200-300mg tablet	Take 1 tablet PO on empty stomach at bedtime.	30	<input type="checkbox"/> <b>Edurant</b>	25mg tablet	Take 1 tablet PO every day with food	30
<input type="checkbox"/> <b>Biktarvy</b>	50-200-25mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Intelence</b>	200mg tablet	Take 1 tablet PO twice daily after meal	60
<input type="checkbox"/> <b>Complera</b>	200-25-300mg tablet	Take 1 tablet PO every day with food	30	<input type="checkbox"/> <b>Pifeltro</b>	100mg tablet	Take 1 tablet PO every day	30
<input type="checkbox"/> <b>Delstrigo</b>	100-300-300mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Sustiva</b>	600mg tablet	Take 1 tablet PO on empty stomach at bedtime	30
<input type="checkbox"/> <b>Dovato</b>	50-300mg tablet	Take 1 tablet PO every day	30	<b>Integrase Inhibitors</b>			
<input type="checkbox"/> <b>Genvoya</b>	150-150-200-10mg tablet	Take 1 tablet PO every day with food	30	<input type="checkbox"/> <b>Isentress</b>	400mg tablet	Take 1 tablet PO twice daily	60
<input type="checkbox"/> <b>Juluca</b>	50-25mg tablet	Take 1 tablet PO every day with food	30	<input type="checkbox"/> <b>Isentress HD</b>	600mg tablet	Take 2 tablets PO every day	60
<input type="checkbox"/> <b>Odefsey</b>	200-25-25mg tablet	Take 1 tablet PO every day with food	30	<input type="checkbox"/> <b>Tivicay</b>	50mg tablet	<input type="checkbox"/> Take 1 tablet PO every day <input type="checkbox"/> Take 1 tablet PO twice daily	<input type="checkbox"/> 30 <input type="checkbox"/> 60
<input type="checkbox"/> <b>Stribild</b>	150-150-200-300mg tablet	Take 1 tablet PO every day with food	30	<b>Protease Inhibitors</b>			
<input type="checkbox"/> <b>Symtuza</b>	800-150-200-10mg tablet	Take 1 tablet PO every day with food	30	<input type="checkbox"/> <b>Kaletra</b>	200-50mg tablet	Take 2 tablets PO twice daily with food	120
<input type="checkbox"/> <b>Triumeq</b>	600-50-300mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Prezcobix</b>	800-150mg tablet	Take 1 tablet PO every day with food	30
<b>Nucleoside Reverse Transcriptase Inhibitors (NRTIs)</b>				<input type="checkbox"/> <b>Prezista</b>	<input type="checkbox"/> 600mg tablet <input type="checkbox"/> 800mg tablet	<input type="checkbox"/> Take 1 tablet PO twice daily with food <input type="checkbox"/> Take 1 tablet PO every day with food	<input type="checkbox"/> 60 <input type="checkbox"/> 30
<input type="checkbox"/> <b>Cimduo</b>	300-300mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Reyataz</b>	150mg capsule	Take 2 capsules PO every day with food	60
<input type="checkbox"/> <b>Combivir</b>	150-300mg tablet	Take 1 tablet PO twice daily	60	<input type="checkbox"/> <b>Viracept</b>	<input type="checkbox"/> 250mg tablet <input type="checkbox"/> 625mg tablet	<input type="checkbox"/> Take 3 tablets PO 3 times daily <input type="checkbox"/> Take 2 tablets PO twice daily	<input type="checkbox"/> 270 <input type="checkbox"/> 120
<input type="checkbox"/> <b>Descovy</b>	200-25mg tablet	Take 1 tablet PO every day	30	<b>Entry Inhibitors</b>			
<input type="checkbox"/> <b>Epzicom</b>	600-300mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Selzentry</b>	<input type="checkbox"/> 150mg tablet <input type="checkbox"/> 300mg tablet	Take 1 tablet PO twice daily	60
<input type="checkbox"/> <b>Retrovir</b>	300mg tablet	Take 1 tablet PO twice daily	60	<b>Pharmacokinetic Enhancers</b>			
<input type="checkbox"/> <b>Truvada</b>	200-300mg tablet	Take 1 tablet PO every day	30	<input type="checkbox"/> <b>Norvir</b>	100mg tablet	Take _____ tablets PO twice daily with food	_____
<b>Other</b>				<input type="checkbox"/> <b>Tyboost</b>	150mg tablet	Take 1 tablet PO once daily with food	30

\*These are standard dosing recommendations - dosing and administration may vary. Please verify dosing prior to selection based on individual parameters. By signing this form and utilizing our services, you are authorizing FountainRx or its designee to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Refills: \_\_\_\_\_