

Deliver to: Patient's Home Prescriber's Office Other: _____ 340B Eligible: Yes No

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SSN: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt Phone: _____ Alternate Contact Info: _____
 Gender: Male Female Allergies: _____ E-Mail: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Tel: _____ Fax: _____
 Contact Person: _____ E-Mail: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF FRONT AND BACK OF INSURANCE CARD

DIAGNOSIS **CLINICAL INFORMATION**

<input type="checkbox"/> Z20.6 Contact with and (suspected) exposure to HIV <input type="checkbox"/> Z20.2 Contact with and (suspected) exposure to infection with a predominantly sexual mode of transmission <input type="checkbox"/> Other: _____	<input type="checkbox"/> Naïve to treatment <input type="checkbox"/> Experienced to treatment <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th rowspan="2" style="width: 30%;">Lab</th> <th colspan="2" style="text-align: center;">Lab Values</th> </tr> <tr> <th style="width: 35%;">Baseline</th> <th style="width: 35%;">Current</th> </tr> </thead> <tbody> <tr> <td>CD4/T-Cell Count</td> <td style="width: 35%;"></td> <td style="width: 35%;"></td> </tr> <tr> <td>HIV/RNA</td> <td></td> <td></td> </tr> </tbody> </table>	Lab	Lab Values		Baseline	Current	CD4/T-Cell Count			HIV/RNA		
Lab	Lab Values											
	Baseline	Current										
CD4/T-Cell Count												
HIV/RNA												

PRESCRIPTION INFORMATION

Medication	Directions	QTY	Refill
<input type="checkbox"/> Descovy	<input type="checkbox"/> Take 1 tablet by mouth daily	30	_____
<input type="checkbox"/> Truvada	<input type="checkbox"/> Take 1 tablet by mouth daily	30	_____

PRESCRIBER SIGNATURE No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.
 (Prescriber, please sign and date below)

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ **Dispense as written (DAW) Date:** ____/____/____

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