PREMIER
PHARMACY SERVICES

PrEP
Prescription Order Form

To ePrescribe send prescription to:
Phone: 800.540.4700
Fax: 800-540-3400
410 Cloverleaf Drive
Baldwin Park, CA 91706

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

☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z20.2 Contact with and (suspected) exposure to infection with a predominantly sexual mode of transmission

☐ Other: _____

CLINICAL INFORMATION

☐ Naïve to treatment ☐ Experienced to treatment

	Lab Values	
Lab	Baseline	Current
CD4/T-Cell Count		
HIV/RNA		

PRESCRIPTION INFORMATION

Medication	Directions	QTY	Refill
☐ Descovy	☐ Take 1 tablet by mouth daily	30	_____
☐ Truvada	☐ Take 1 tablet by mouth daily	30	_____

PRESCRIBER SIGNATURE

(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

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:** _____/_____/_____

(Intentionally left blank)