Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

HIV PREP/PEP ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up ☐ Store Preference (address): ________________ **Rx:** ☐ New ☐ Refill

Patient Information

Date: ____________________ ☐ Male ☐ Female DOB: ________________

Patient's First Name: ____________________ Patient's Last Name: ____________________

Address: ____________________ City: ____________ State: ______ ZIP: ________

Best Phone Number: ____________________ Alternate Phone Number: ____________________

Allergies: ____________________

Height: ______________ Weight: ____________ ☐ kgs. or ☐ lbs.

Emergency Contact Name: ____________________ Emergency Contact Phone #: ________________

Insurance Information: Please fax copy of insurance card (front + back)

Clinical Info.

Diagnosis ICD-10: __________ ☐ HIV Pre-Exposure Prophylaxis (PREP) ☐ HIV Post-Exposure Prophylaxis (PEP)

New to current therapy? ☐ yes ☐ no

HIV Screening: ☐ HIV-1 Results: ________________ ☐ HBV Results: ________________

PREP

HIV Pre-Exposure Prophylaxis (PREP)

☐ Truvada 200mg/300mg tabs
Dispense 30 tabs
Take 1 tablet PO once daily for ________ days.
Refills x ___________

PEP

HIV Post-Exposure Prophylaxis (PEP)

Option 1

☐ Truvada 200mg/300mg tabs
Dispense 30 tabs
Take 1 tablet PO once daily for ______ days.
Refills x _____ ☐ discard remainder

☐ Tivicay 50mg
Dispense 30 tabs
Take 1 tablet PO once daily for ______ days.
Refills x _____ ☐ discard remainder

Option 2

☐ Truvada 200mg/300mg tabs
Dispense 30 tabs
Take 1 tablet PO once daily for ______ days.
Refills x _____ ☐ discard remainder

☐ Isentress 400mg tabs
Dispense 60 tabs
Take 1 tablet PO twice daily for ______ days.
Refills x _____ ☐ discard remainder

Clinical Info: ☐ Date of HIV exposure ______________
Was the patient provided with medication? ☐ yes ☐ no if yes, how many days supply __________

HIV Post-Exposure Prophylaxis (PEP) medication therapy is for 28 days

Prescriber Information

Date Prescription Needed: ____________________

Physician Name (please print): ____________________ Contact Name: ____________________

Phone #: ______________ Fax #: ______________ NPI #: ______________

Office Address: ______________ City: ______________ State: ________ ZIP: ________

State License #: ____________________ DEA #: ____________________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: ______________________________ **Date:** ______________