HIV Post-Exposure Prophylaxis (PEP) Enrollment Form

PLEASE FAX TO: 207-899-0968

PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name:	Date of Birth: ☐ Male ☐ Female
Address:	
Phone:	Alternate Phone:
Does the patient have prescription insurance? ☐ Yes ☐No	If yes, please send a copy of the patient's prescription insurance card (if available).
	If no, please send a Treating Provider Letter (see below).

CLINICAL INFORMATION

Diagnosis : (Z20.6) ☐ **Non-Occupational Post Exposure Prophylaxis (nPEP)** ☐**Occupational Post Exposure Prophylaxis (PEP)**	**Date of Exposure:** _________________ **Time of Exposure:** _________________ **Verified exposure within the last 72 hours:** ☐ **Yes** ☐**No**
Allergies:	**Height:** _________________ **Weight:** _________________

Include the following EXTRA information, if available. If unavailable, still send in this Rx form to ABD to ensure prompt medication dispensing:

HIV Test Results : ☐ **Negative** ☐**Positive**	**Confirmed Negative Pregnancy test:** ☐ **Yes** ☐**No**
Hep C Antibody: ☐ **Negative** ☐**Positive**	**Estimated GFR:**
Hep B Antigen: ☐ **Negative** ☐**Positive** **Hep B Antibody:** ☐ **Negative** ☐**Positive**	**Hep B Core Antibody:** ☐ **Negative** ☐**Positive**

TREATING PROVIDER LETTER INCLUSIONS

☐ **Patient name, birthday, address**	☐ **Brief medical description of nPEP or PEP need**
☐ **Statement patient has not yet received treatment**	☐ **Date/Time of exposure**
☐ **Treatment medications, instructions, duration**	☐ **Address letter "To whom it may concern"**
☐ **Provider's name, DEA, NPI, signature**	

DRUG	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **Truvada** (emtricitabine/tenofovir disoproxil fumarate)	☐ **200/300mg**	**Take 1 tablet by mouth once daily**	**30**	**0**
AND				
☐ **Tivicay** (dolutegravir)	☐ **50mg**	**Take 1 tablet by mouth once daily**	**30**	**0**
☐ **Isentress** (raltegravir) *Alternative to Tivicay; free drug for uninsured patients must come from manufacturer. 24 to 48 hour turn around	☐ **400mg**	**Take 1 tablet by mouth twice daily**	**60**	**0**

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified.