HIV Post-Exposure Prophylaxis (PEP) Enrollment Form

ABD Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

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).

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**

Drug Allergies: _____

Patient on birth control: ☐ **Yes** ☐ **No** ☐ **Unknown**

CrCl > 50mL/min: ☐ **Yes** ☐ **No** ☐ **Unknown**

Height: _____

Weight: _____

DRUG	DOSE/STRENGTH	DIRECTIONS	QTY	REF
☐ **Truvada** (emtricitabine/tenofovir disoproxil fumarate)	☐ **200/300 mg**	**Take 1 tablet by mouth once daily**	**30**	**0**
AND				
☐ **Tivicay** (dolutegravir)	☐ **50 mg**	**Take 1 tablet by mouth once daily**	**30**	**0**
*Unbroken bottles of 30 day supply must be dispensed				
OR				
☐ **Isentress** (raltegravir) Alternative to Tivicay; if patient has no insurance Isentress must come directly via mail order from manufacturer. Up to 48 hour turnaround. **Call ABD for more details.**	☐ **400 mg**	**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.