



HIV Post-Exposure Prophylaxis (PEP) Enrollment Form

PLEASE FAX TO: 207-899-0968

PHONE: 207-899-0939

PATIENT INFORMATION	
Patient Name:	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	
Phone:	Alternate Phone:
Does the patient have prescription insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please send a copy of the patient's prescription insurance card (if available).	

CLINICAL INFORMATION	
Diagnosis : <input type="checkbox"/> Non-Occupational Post Exposure Prophylaxis (nPEP) (Z20.6) <input type="checkbox"/> Occupational Post Exposure Prophylaxis (PEP)	Date of Exposure: _____ Time of Exposure: _____ Verified Exposure Within the Last 72 Hours: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Allergies: _____ Patient on birth control: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown CrCl > 50mL/min: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Height: _____ Weight: _____

DRUG	DOSE/STRENGTH	DIRECTIONS	QTY	REF
<input type="checkbox"/> Truvada (emtricitabine/tenofovir disoproxil fumarate) AND <input type="checkbox"/> Tivicay (dolutegravir)	<input type="checkbox"/> 200/300 mg <input type="checkbox"/> 50 mg	Take 1 tablet by mouth once daily Take 1 tablet by mouth once daily	30 30	0 0
*Unbroken bottles of 30 day supply must be dispensed				
OR				
<input type="checkbox"/> 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.	<input type="checkbox"/> 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.

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