BioPlus® Specialty Pharmacy

A Carelon Company

# Infectious Disease

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

## Patient Information

| | |
|---|---|
| Patient Name | |
| Address | |
| City State ZIP | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐Female ☐Male |

## Prescriber Information

| | | |
|---|---|---|
| Prescriber Name | | |
| Address | | |
| City State ZIP | | |
| Phone | Fax | |
| Contact Person | | |
| DEA # | NPI # | License # |

## Clinical Information

| | | | |
|---|---|---|---|
| Primary Diagnosis: ☐ B20 HIV/AIDS<br>☐ PREP; ICD-10: _____ ☐ PEP; ICD-10: _____ | | Comorbidities: ☐ B18.1 Hepatitis B (chronic) ☐ B18.2 Hepatitis C (chronic)<br>☐ R64: Cachexia (HIV wasting) ☐ Other: _____ | |
| CD4 Cell Count | Viral Load/HIV RNA | CrCl | Date of Lab |
| Is Patient Currently on Therapy: ☐ No ☐ Yes | | Has Patient Been Treated Previously for this Condition: ☐ No ☐ Yes<br>If Yes, Medication: _____ | |
| Drug Allergies | | Weight ☐ kg ☐ lbs | Status:<br>☐ New ☐ Restart ☐ Continuing |

| Medication | Dose/Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| **Complete Regimens** | | | | |
| ☐ Atripla® | 600 mg-300 mg-200 mg Tablet | 1 tablet by mouth once daily on empty stomach | _____ | _____ |
| ☐ Biktarvy® | 50 mg-25 mg-200 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Cabenuva® | ☐ Oral Lead-In (Theracon distributed) (cabotegravir 30 mg tablet/ rilpivirine 25 mg tablet) | 1 tablet by mouth once daily with food/<br>1 tablet by mouth once daily with food | 30<br>30 | None<br>None |
| | **Every 2-Month Dosing**<br>☐ 600 mg-900 mg Injections | ☐Load: 2 injections intramuscularly on month 1 and 2, and 2 injections every 2 months thereafter<br>☐Maintenance: 2 injections intramuscularly every 2 months | 1 Kit<br>1 Kit | 1 Refill<br>_____ |
| | **Once Monthly Dosing**<br>☐ Initiation Injections (600 mg-900 mg)<br>☐ Continuation Injections (400 mg-600 mg) | 2 injections intramuscularly, once<br>2 injections intramuscularly, monthly | 1 Kit<br>1 Kit | None<br>_____ |
| ☐ Complera® | 25 mg-300 mg-200 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Delstrigo® | 100 mg-300 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Dovato® | 50 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Genvoya® | 150 mg-150 mg-10 mg-200 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Juluca® | 50 mg-25 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Odefsey® | 25 mg-25 mg-200 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Stribild® | 150 mg-150 mg-300 mg-200 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Symfi® | 600 mg-300 mg-300 mg Tablet | 1 tablet by mouth once daily on empty stomach | _____ | _____ |
| ☐ Symfi Lo® | 400 mg-300 mg-300 mg Tablet | 1 tablet by mouth once daily on empty stomach | _____ | _____ |
| ☐ Symtuza® | 800 mg-150 mg-10 mg-200 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Triumeq® | 50 mg-600 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |



**Prescriber's Signature** (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**

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## Patient Information

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| Address | |
| City State ZIP | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐ Female ☐ Male |

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| Drug Allergies | Weight ☐ kg ☐ lbs / Status: ☐ New ☐ Restart ☐ Continuing |

| Medication | Dose/Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| **NRTI** | | | | |
| ☐ Cimduo® | 300 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Combivir® | 300 mg-150 mg Tablet | 1 tablet by mouth twice daily | _____ | _____ |
| ☐ Descovy® | 25 mg-200 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Emtriva® | ☐ 200 mg Capsule ☐ 10 mg/mL Solution | _____ | _____ | _____ |
| ☐ Epivir® | ☐ 100 mg Tablet ☐ 150 mg Tablet ☐ 300 mg Tablet<br>☐ 5 mg/mL Solution ☐ 10 mg/mL Solution | _____ | _____ | _____ |
| ☐ Epzicom® | 600 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Retrovir® | ☐ 100 mg Tablet ☐ 300 mg Tablet ☐ 10 mg/mL Soutioln | _____ | _____ | _____ |
| ☐ Temyxis® | 300 mg-300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Truvada® | ☐ 300-200 mg Tablet ☐ 250-167 mg Tablet<br>☐ 200-133 mg Tablet ☐ 150-100 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Viread® | 300 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Ziagen® | 300 mg Tablet | ☐ 1 tablet by mouth twice daily<br>☐ 2 tablets by mouth once daily | _____ | _____ |
| **NNRTI** | | | | |
| ☐ Edurant® | 25 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Intelence® | ☐ 25 mg Tablet ☐ 100 mg Tablet ☐ 200 mg Tablet | _____ | _____ | _____ |
| ☐ Pifeltro® | 100 mg Tablet | 1 tablet by mouth once daily | _____ | _____ |
| ☐ Sustiva® | ☐ 50 mg Tablet ☐ 200 mg Tablet ☐ 600 mg Tablet | 1 tablet by mouth once daily on empty stomach | _____ | _____ |
| ☐ Viramune® | ☐ 200 mg Tablet ☐ 50 mg/5 mL Soln | _____ | _____ | _____ |
| ☐ Viramune XR® | ☐ 100 mg Tablet ☐ 400 mg Tablet | _____ | _____ | _____ |
| **Integrase Inhibitor** | | | | |
| ☐ Isentress® | ☐ 400 mg Tablet ☐ 600mg Tablet | _____ | _____ | _____ |
| ☐ Tivicay® | 50 mg Tablet | ☐ For naive: 1 tablet by mouth once daily<br>☐ For experienced: 1 tablet by mouth twice daily | _____ | _____ |
| **Entry Inhibitor** | | | | |
| ☐ Fuzeon® | 90 mg/1 mL Soln | 1 mL (90 mg) under the skin twice daily | _____ | _____ |
| ☐ Rukobia® | 600 mg Tablet | 1 tablet by mouth twice daily | _____ | _____ |
| ☐ Selzentry® | ☐ 150 mg Tablet ☐ 300 mg Tablet | _____ | _____ | _____ |



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| Is Patient Currently on Therapy: ☐ No ☐ Yes | Has Patient Been Treated Previously for this Condition: ☐ No ☐ Yes<br>If Yes, Medication: _____ |
| Drug Allergies | Weight ☐ kg ☐ lbs / Status: ☐ New ☐ Restart ☐ Continuing |

| Medication | Dose/Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| **PK Booster** | | | | |
| ☐ Norvir® | ☐ 100 mg Tablet ☐ 80mg/mL Solution | _____ | _____ | _____ |
| ☐ Tybost®® | 150 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| **Protease Inhibitors (PI)** | | | | |
| ☐ Aptivus® | ☐ 250 mg Capsule ☐ 100 mg/mL Solution | _____ | _____ | _____ |
| ☐ Crixivan® | ☐ 400 mg Capsule | ☐ 2 capsules by mouth every 8 hours on empty stomach<br>☐ Take 2 capsules by mouth with NORVIR® twice daily | _____ | _____ |
| ☐ Evotaz® | 300 mg-150 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Kaletra® | ☐ 100-25 mg Tablet ☐ 200-50 mg Tablet ☐ 80 mg-20 mg/mL Solution | _____ | _____ | _____ |
| ☐ Lexiva® | ☐ 700 mg Tablet ☐ 50 mg/mL Susp | _____ | _____ | _____ |
| ☐ Prezcobix® | 800 mg-150 mg Tablet | 1 tablet by mouth once daily with food | _____ | _____ |
| ☐ Prezista® | ☐ 75 mg Tablet ☐ 150 mg Tablet ☐ 600 mg Tablet<br>☐ 800 mg Tablet ☐ 100 mg/mL Susp | _____ | _____ | _____ |
| ☐ Reyataz® | ☐ 150 mg Capsule ☐ 200 mg Capsule ☐ 300 mg Capsule<br>☐ 50 mg Packet | _____ | _____ | _____ |
| ☐ Viracept® | ☐ 250 mg Capsule ☐ 625 mg Capsule | _____ | _____ | _____ |
| **PrEP Only Regimen** | | | | |
| ☐ Apretude | ☐ Oral Lead-In (Theracom distributed; optional) (cabotegravir 30 mg tablet) | 1 tablet by mouth once daily with food | 30 | None |
| | ☐ 600 mg Injection | ☐ Load: 1 injection intramuscularly on month 1 and 2, then 1 injection every 2 months thereafter<br>☐ Maintenance: 1 injection intramuscularly every 2 months | 1 Kit<br>1 Kit | 1 Refill<br>_____ |
| **Growth Hormone** | | | | |
| ☐ Egrifta SV® | 2 mg Vial | Inject 1.4 mg under the skin once daily | 30 | _____ |
| ☐ Serostim® | ☐ 4 mg Vial ☐ 5 mg Vial ☐ 6 mg Vial | Inject _____ mg under the skin once daily at bedtime | 28 | _____ |
| Ancillary | ☐ BD 3 mL 20 g x 1" Syringe<br>☐ 30 g x 0.5" Needles | Use as directed with SEROSTIM® | QS | _____<br>_____ |
| **Other** | | | | |
| ☐ | | | | |
| ☐ | | | | |



**Prescriber's Signature** (no stamps) **Substitution Permitted** _____ **Date** _____

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