

## **Infectious Disease**

A Carelon Company

Fax: 800-269-5493

Phone: 888-292-0744

bioplusrx.com

Need By Date:

1 4/1 000 200 0

Ship To: 
Patient 
Office 
Other

Fax Copy: □ Rx Card Front/Back □ Clinical Notes □ Medical Card Front/Back

| Patient Information  |                    | Prescriber Information   |   |  |                     |  |
|--|--------------------|--|---|--|---------------------|--|
| Patient Name   |                    | Prescriber Name  |   |  |                     |  |
| Address  |                    | Address  |   |  |                     |  |
| City State ZIP   |                    | City State ZIP   |   |  |                     |  |
| Main Phone   | Alternate Phone    | Phone Fax  |   |  |                     |  |
| Social Security #  |                    | Contact Person   |   |  |                     |  |
| Date of Birth  | □Female □Male      | DEA # NPI # License #  |   |  | License #           |  |
|  | Clinical In        | formation  |   |  |                     |  |
| Primary Diagnosis:  B20 HIV/AIDS PREP; ICD-10:  PEP; ICD-10: |                    | Comorbidities:  B18.1 Hepatitis B (chronic)  B18.2 Hepatitis C (chronic) 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 If Yes, Medication:                          |   |  | Yes                 |  |
| Drug Allergies   |                    |  | □ kg □ lbs Status:<br>□ New □ Restart □ Conti |  | estart   Continuing |  |

| Medication              | Dose/Strength   | Directions   | Qty            | Refills      |
|-------------------------|---|--|----------------|--------------|
| Complete Regim          | iens  |  |                |              |
| □ Atripla <sup>®</sup>  | 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®             | <ul> <li>Oral Lead-In (Theracon distributed)<br/>(cabotegravir 30 mg tablet/<br/>rilpivirine 25 mg tablet)</li> </ul> | 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,<br>and 2 injections every 2 months thereafter<br>□Maintenance: 2 injections intramuscularly every 2 months | 1 Kit<br>1 Kit | 1 Refill     |
|                         | 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         |
| Complera®               | 25 mg-300 mg-200 mg Tablet  | 1 tablet by mouth once daily with food   |                |              |
| Delstrigo <sup>®</sup>  | 100 mg-300 mg-300 mg Tablet   | 1 tablet by mouth once daily   |                |              |
| □ Dovato <sup>®</sup>   | 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 <sup>®</sup> | 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   |                |              |

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.



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Fax Copy: 🗆 Rx Card Front/Back 🗆 Clinical Notes 🗆 Medical Card Front/Back

|                                    | Patient In                                 | formation  | Pre   | scriber I           | nforma               | tion             |         |
|------------------------------------|--|--|---|---------------------|----------------------|------------------|---------|
| Patient Name                       |  |  | Prescriber Name   |                     |                      |                  |         |
| Address                            |  |  | Address   |                     |                      |                  |         |
| City State ZIP                     |  |  | City State ZIP  |                     |                      |                  |         |
| Main Phone                         |  | Alternate Phone  | Phone Fax   |                     |                      |                  |         |
| Social Security #                  |  |  | Contact Person  |                     |                      |                  |         |
| Date of Birth                      |  | Female      Male   | DEA# NPI#   |                     |                      | License #        |         |
|                                    |  | Clinical In  | oformation  |                     |                      |                  |         |
| Primary Diagnosis: 🗆 Bź            |  |  |   |                     |                      |                  |         |
| PREP; ICD-10:                      |  | □ PEP; ICD-10:   | Comorbidities:  B18.1 Hepatitis   | B (chronic)         | 318.2 Hepatitis      | C (chronic)      |         |
| CD4 Cell Count                     |  | Viral Load/HIV RNA   | CrCl  |                     | Date of Lab          |                  |         |
| Is Patient Currently on Th         | erapy: 🗆 No 🛛 Yes                          |  | Has Patient Been Treated Previou<br>If Yes, Medication:   | Isly for this Condi | ion: 🗆 No 🛛          | Yes              |         |
| Drug Allergies                     |  |  | Weight  | □ kg □ lbs          | Status:<br>□ New □ F | Restart 🗆 Contin | uing    |
| Medication                         |  | Dose/Strength  | Direct  | ions                |                      | Qty              | Refills |
| NRTI                               |  |  |   |                     |                      |                  |         |
| □ Cimduo®                          | 300 mg-300 mg Tablet                       |  | 1 tablet by mouth once daily  |                     |                      |                  |         |
| Combivir <sup>®</sup>              | 300 mg-150 mg Tablet                       |  | 1 tablet by mouth twice daily   |                     |                      |                  |         |
|                                    | 25 mg-200 mg Tablet                        |  | 1 tablet by mouth once daily  |                     |                      |                  |         |
| Emtriva®                           | □ 200 mg Capsule                           | □ 10 mg/mL Solution  |   |                     |                      |                  |         |
|                                    | □ 100 mg Tablet<br>□ 5 mg/mL Solution      | □ 150 mg Tablet □ 300 mg Tablet<br>□ 10 mg/mL Solution   |   |                     |                      |                  |         |
|                                    | 600 mg-300 mg Tablet                       |  | 1 tablet by mouth once daily  |                     | -                    |                  |         |
| □ Retrovir <sup>®</sup>            | □ 100 mg Tablet                            | □ 300 mg Tablet □ 10 mg/mL Soutioln  |   |                     |                      |                  |         |
| □ Temyxis <sup>®</sup>             | 300 mg-300 mg Tablet                       |  | 1 tablet by mouth once daily  |                     | -                    |                  |         |
| □ Truvada®                         | □ 300-200 mg Tablet<br>□ 200-133 mg Tablet | □ 250-167 mg Tablet<br>□ 150-100 mg Tablet   | 1 tablet by mouth once daily  |                     | -                    |                  |         |
| □ Viread <sup>®</sup>              | 300 mg Tablet                              |  | 1 tablet by mouth once daily  |                     | -                    |                  |         |
| □ Ziagen®                          | 300 mg Tablet                              |  | <ul> <li>□ 1 tablet by mouth twice daily</li> <li>□ 2 tablets by mouth once daily</li> </ul>    |                     | -                    |                  |         |
| NNRTI                              |  |  |   |                     |                      |                  |         |
| □ Edurant <sup>®</sup>             | 25 mg Tablet                               |  | 1 tablet by mouth once daily with f   | ood                 | -                    |                  |         |
| □ Intelence®                       | □ 25 mg Tablet                             | □ 100 mg Tablet □ 200 mg Tablet  |   |                     |                      |                  |         |
| □ Pifeltro <sup>®</sup>            | 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 er  | npty stomach        | -                    |                  |         |
| □ Viramune®                        | □ 200 mg Tablet                            | □ 50 mg/5 mL Soln  |   |                     |                      |                  |         |
| □ Viramune XR®                     | □ 100 mg Tablet                            | □ 400 mg Tablet  |   |                     |                      |                  |         |
| Integrase Inhibit                  | tor  |  |   |                     |                      |                  |         |
| □ Isentress®                       | □ 400 mg Tablet                            | □ 600mg Tablet   |   |                     |                      |                  |         |
| □ Tivicay®                         | 50 mg Tablet                               |  | <ul> <li>□ For naive: 1 tablet by mouth or</li> <li>□ For experienced: 1 tablet by m</li> </ul> |                     | -                    |                  |         |
| 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  |   |                     |                      |                  |         |
| and dose for this patient. IMPORTA | ANT NOTICE: This fax is intende            | y and its employees to serve as your designated agent in submitting cli<br>ad to be delivered only to the named addressee. It contains material I<br>mediately if you have received this document in error and then destro | hat is confidential, privileged property, or exemp  |                     |                      |                  |         |

Date

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|---|-----------------------------------|--|-----------|-------------|-----------|--|
| Patient In  | formation                         | Pre  | scriber I | nformat     | ion       |  |
| Patient Name  |                                   | Prescriber Name  |           |             |           |  |
| Address   |                                   | Address  |           |             |           |  |
| City State ZIP  |                                   | City State ZIP   |           |             |           |  |
| Main Phone  | Alternate Phone                   | Phone Fax  |           |             |           |  |
| Social Security #   |                                   | Contact Person   |           |             |           |  |
| Date of Birth   | 🗆 Female 🗆 Male                   | DEA#   | NPI# Lic  |             | License # |  |
|   | Clinical In                       | formation  |           |             |           |  |
| Primary Diagnosis: □ B20 HIV/AIDS<br>□ PREP; ICD-10: □ PEP; ICD-10: |                                   | Comorbidities:  B18.1 Hepatitis B (chronic)  B18.2 Hepatitis C (chronic) R64: Cachexia (HIV wasting)  Other: |           |             | ,         |  |
| CD4 Cell Count  | Viral Load/HIV RNA                | CrCl   |           | Date of Lab |           |  |

| CD4 Cell Count  | Viral Load/HIV RNA                  | CrCl              | Date of Lab      |
|---|-------------------------------------|-------------------|------------------|
| Is Patient Currently on Therapy: $\Box\;$ No $\;\;\Box\;$ Yes | at Currently on Therapy: □ No □ Yes |                   | tion: 🗆 No 🔲 Yes |
| Drug Allergies  |                                     | Weight 🗆 kg 🗆 lbs | Status:          |
|   |                                     |                   |                  |

| Medication                        | Dose/Strength                                  |                                       | Directions                |                      | Qty   | Refills        |          |
|-----------------------------------|--|---------------------------------------|---------------------------|----------------------|---|----------------|----------|
| PK Booster                        |  |                                       |                           |                      |   |                |          |
| □ Norvir <sup>®</sup>             | □ 100 mg Tablet                                | □ 80mg/mL Solution                    |                           |                      |   |                |          |
| □ Tybost®®                        | 150 mg Tablet                                  |                                       |                           | 1 tablet by m        | nouth once daily with food  |                |          |
| Protease Inhibit                  | ors (PI)                                       |                                       |                           |                      |   |                |          |
| □ Aptivus <sup>®</sup>            | □ 250 mg Capsule                               | □ 100 mg/mL Solutio                   | n                         |                      |   |                |          |
| □ Crixivan <sup>®</sup>           | □ 400 mg Capsule                               |                                       |                           |                      | es by mouth every 8 hours on empty stomach<br>apsules by mouth with NORVIR® twice daily   |                |          |
| □ Evotaz <sup>®</sup>             | 300 mg-150 mg Tablet                           | t                                     |                           | 1 tablet by m        | nouth 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                           | t                                     |                           | 1 tablet by m        | nouth once daily with food  |                |          |
| □ Prezista®                       | □ 75 mg Tablet<br>□ 800 mg Tablet              | □ 150 mg Tablet<br>□ 100 mg/mL Susp   | □ 600 mg Tablet           |                      |   |                |          |
| □ Reyataz®                        | □ 150 mg Capsule<br>□ 50 mg Packet             | □ 200 mg Capsule                      | □ 300 mg Capsule          |                      |   |                |          |
| □ Viracept <sup>®</sup>           | □ 250 mg Capsule                               | □ 625 mg Capsule                      |                           |                      |   |                |          |
| PrEP Only Regin                   | nen  |                                       |                           |                      |   |                |          |
| Apretude                          | Oral Lead-In (Thera<br>(cabotegravir 30 mg     | acom distributed; option<br>a tablet) | al)                       | 1 tablet by m        | nouth once daily with food  | 30             | None     |
|                                   | □ 600 mg Injection                             |                                       |                           | then 1 inje          | njection intramuscularly on month 1 and 2,<br>action every 2 months thereafter<br>nce: 1 injection intramuscularly every 2 months                             | 1 Kit<br>1 Kit | 1 Refill |
| Growth Hormon                     | e  |                                       |                           |                      | ····· · · · · · · · · · · · · · · · ·   |                |          |
| □ Egrifta SV®                     | 2 mg Vial                                      |                                       |                           | Inject 1.4 mg        | g under the skin once daily   | 30             |          |
| □ Serostim <sup>®</sup>           | □ 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" 3<br>□ 30 g x 0.5" Needles |                                       |                           | Use as direc         | ted with SEROSTIM®  | QS             |          |
| Other                             |  |                                       |                           |                      |   |                |          |
|                                   |  |                                       |                           |                      |   |                |          |
|                                   |  |                                       |                           |                      |   |                |          |
| and dose for this patient. IMPORT | ANT NOTICE: This fax is intend                 | led to be delivered only to the r     |                           | hat is confidential, | uired information to third party payers with respect to this prescriptio<br>privileged property ,or exempt from disclosure under applicable lar<br>mediately. |                |          |

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Date