HIV AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PraxisRx

PATIENT INFORMATION

Patient:_____ Caregiver: _____

DOB:_____ ☐ Male or ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Allergies:_____

Address:_____ City:_____ State:_____ Zip:_____

Primary Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell

Email:_____

CLINICAL INFORMATION

DIAGNOSIS: ☐ B20 HIV ☐ B18.0 HBV with delta agent (Chronic) ☐ B18.1 HBV without delta agent (Chronic) ☐ B18.2 HCV (Chronic)

New to current therapy ☐ Yes ☐ No ☐ CD4: _____ Date:_____ HIV RNA: _____ Date:_____

ANTIRETROVIRALS (ARVS)

MEDICATION	QTY	REFILLS	MEDICATION	QTY	REFILLS
☐ Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)			☐ Prezcobix® (DRV/COBI) 800/150 mg One tablet QD with food		
☐ Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empy stomach			☐ Prezista® (darunavir) (DRV) 100 mg _____		
☐ Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)			☐ Rescriptor® (delavirdine) (DLV) 100 or 200 mg _____		
☐ Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food			☐ Retrovir® (zidovudine) (ZDV) _____ _____		
☐ Crixivan® (indinavir) (IDV) 200 or 400 mg One tablet by mouth QD with a meal			☐ Reyataz® (atazanavir) (ATV) _____ _____		
☐ Descovy® (FTC/TDF) 200/25 mg One tablet by mouth QD			☐ Selzentry® (maraviroc) (MVC) 150 or 300 mg _____		
☐ Edurant® (rilpivirine) (RPV) 25 mg One capsule by mouth QD			☐ Stribid™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
☐ Emtrivia® (emtricitabine) (FTC) 200 mg One capsule by mouth QD			☐ Sustiva® (efavirenz) (EFV) _____ _____		
☐ Epivir® (lamivudine) (3TC) _____ _____			☐ Tivicay® (dolutegravir) (DTG) 50 mg _____		
☐ Epzicom® (abacavir/lamivudine) (ABC/3TC) 600/300 mg One tablet by mouth QD			☐ Triumeq® (ABC/DTG/3TC) 600/50/300 mg One tablet by mouth daily		
☐ Evotaz™ (ATV/COBI) 300/150 mg One tablet by mouth QD			☐ Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet BID (Q12 hours)		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)			☐ Truvada® (emtricitabine/tenofovir) (FTC/TDF) 200/300 mg One tablet by mouth QD		
☐ Genvoya® (COBI/EVG/FTC/TDF) 150/150/200/10 mg One tablet by mouth QD			☐ Videx® EC (didanosine) (DDL) _____ _____		
☐ Intelence® (etravirine) (ENF) _____ _____			☐ Viracept® (nelfinavir) (NFV) 250 or 625 mg _____		
☐ Invirase® (saquinavir) (SQV) _____ _____			☐ Viramune® (nevirapine) (NVP) 200 mg One tablet by mouth QD		
☐ Isentress® (raltegravir) (RAL) 400 mg One tablet by mouth BID (Q12 hours)			☐ Viramune® XR™ (nevirapine ER) (NVP) 400 mg One tablet by mouth QD		
☐ Kaletra® (lopinavir/ritonavir) 200/50 mg _____			☐ Viread® (tenofovir) (TDF) 300 mg One tablet by mouth QD		
☐ Lexiva® (fosamprenavir) (FPV) 700 mg _____			☐ Vitekta® (elvitegravir) (EVG) 85 or 150 mg _____		
☐ Norvir® (ritonavir) capsules (RTV) 100 mg _____			☐ Zerit® (stavudine) (D4T) _____ _____		
☐ Norvir® (ritonavir) tablets (RTV) 100 mg _____			☐ Ziagen® (abacavir) (ABC) 300 mg One tablet BID or two tablets daily		
☐ Odefsey® (FTC/RPV/TDF) 200/25/25 mg One tablet by mouth QD					

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____

Prescriber: _____ NPI #: _____ Phone #: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip:_____

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _____ Date: _____

☐ DAW, Brand Medically Necessary