Publix Specialty Pharmacy #3213

HIV (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

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

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical information [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ ☐HIV ☐PrEP ☐PEP Baseline Viral Load: _____ CD4 count: _____

Co-infections: ☐None ☐HCV ☐HBV ☐Other: _____ CrCl _____ mL/min, SCr: _____ mg/dL, Date of Labs: _____/_____/_____

Regimen status: ☐New to regimen ☐Continuation of regimen, start date: _____/_____/_____ Height: _____ ☐cm ☐ in

Previously treated: ☐No ☐Yes, previous regimen _____ Weight: _____ ☐kg ☐lb

Allergies: ☐ NKDA ☐Other_____

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/ DAYS	REFILLS
PrEP Therapy	☐ Descovy (FTC/TAF)	200/25 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
	☐ Truvada (FTC/TDF)	200/300 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
Single Tablet Regimens	☐ Atripla (EFV/FTC/TDF)	600/200/300 mg tablet	1 tab PO QHS on an empty stomach	☐30 days ☐90 days	_____
	☐ Biktarvy (BIC/FTC/TAF)	50/200/25 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
	☐ Complera (RPV/FTC/TDF)	25/200/300 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____
	☐ Delstrigo (DOR/3TC/TDF)	100/300/300 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
	☐ Dovato (DTG/3TC)	50/300 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
	☐ Genvoya (EVG/COBI/FTC/TAF)	150/150/200/10 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____
	☐ Juluca (DTG/RPV)	50/25 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____

Prescriber Information

Ship to prescriber: ☐ Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable☐ _____ Supervising Physician NPI # _____

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

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ _____
(stamps not accepted) ☐Substitution allowed Date ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

Publix Specialty Pharmacy #3213

HIV (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐Male ☐Female Caregiver Name:_____

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

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical information [Attach copy of labs and clinical notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ ☐HIV ☐PrEP ☐PEP Baseline Viral Load: _____ CD4 count: _____

Co-infections: ☐None ☐HCV ☐HBV ☐Other: _____ CrCl _____ mL/min, SCr: _____ mg/dL, Date of Labs: _____/_____/_____

Regimen status: ☐New to regimen ☐Continuation of regimen, start date: _____/_____/_____ Height: _____ ☐cm ☐ in

Previously treated: ☐No ☐Yes, previous regimen _____ Weight: _____ ☐kg ☐lb

Allergies: ☐ NKDA ☐Other_____

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/ DAYS	REFILLS
Single Tablet Regimens	☐ Odefsey (RPV/FTC/TAF)	25/200/25 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____
	☐ Stribild (EVG/COBI/FTC/TDF)	150/150/200/300 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____
	☐ Symfi (EFV/3TC/TDF)	600/300/300 mg tablet	1 tab PO QHS on an empty stomach	☐30 days ☐90 days	_____
	☐ Symfi Lo (EFV/3TC/TDF)	400/300/300 mg tablet	1 tab PO QHS on an empty stomach	☐30 days ☐90 days	_____
	☐ Symtuza (DRV/COBI/FTC/TAF)	800/150/200/10 mg tablet	1 tab PO one time daily with food	☐30 days ☐90 days	_____
	☐ Triumeq (DTG/ABC/3TC)	50/600/300 mg tablet	1 tab PO one time daily	☐30 days ☐90 days	_____
Other	☐ _____	_____	_____	_____	_____
	☐ _____	_____	_____	_____	_____
	☐ _____	_____	_____	_____	_____

Prescriber Information Ship to prescriber: ☐ Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable☐ _____ Supervising Physician NPI # _____

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

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted) _____ ☐Substitution allowed Date _____ ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: