briovaRx™

Fax: Select Option Phone: Select Option

HIV Pre-Exposure Prophylaxis (PrEP) Enrollment Form

(Please use black ink)

PATIENT INFORMATION *Please complete the following or **send patient demographic sheet***

Patient Name _____ DOB _____ Last Four of SS# _____ Gender _____

Address _____ City, State, ZIP** _____

Home Phone _____ Alternate Phone _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

NPI _____ DEA _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

Prescriber's Name _____

NPI _____ Office Contact _____

Prescriber's Name _____

NPI _____ Office Contact _____

Prescriber's Name _____

NPI _____ Office Contact _____

INSURANCE INFORMATION *Please fax a copy of patient's insurance card including both sides*

Insurance ID#: Insurance Name:

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis Codes

ICD-10 Code	Description	Use For
☐ Z11.4	Encounter for screening for human immunodeficiency virus (HIV)	HIV screening
☐ Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	HIV, STI screening
☐ Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus (HIV)	HIV screening
☐ Z51.81	Encounter for therapeutic drug level monitoring	PrEP monitoring
☐ Z72.51	High risk heterosexual behavior	HIV, STI screening
☐ Z72.52	High risk homosexual behavior	HIV, STI screening
☐ Z72.53	High risk bisexual behavior	HIV, STI screening

Patient Evaluation

Allergies/Comments _____

Concomitant Medications _____

Patient has been determined to be at high risk for HIV-1 infection ☐ Yes ☐ No

Patient has received counseling on safe sex practices and HIV infection risk ☐ Yes ☐ No

Patient has no clinical symptoms consistent with acute viral infection ☐ Yes ☐ No

Patient has a confirmed negative HIV-1 status within the past 2 weeks ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Direction	Quantity	Refills
☐ Truvada	200-300mg	Take one tablet by mouth daily	30	2
☐ Truvada	200-300mg	Take one tablet by mouth daily	90	0

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

** State of New York has to Send E-script along with this Enrollment Form

Prescriber's Signature _____ _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*

Supervising Physician/Supervising Physician Signature _____ Date _____

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