

Phone: 1-800-237-2767 Email Referral To: Customer.ServiceFax@CVSHealth.com

PATIENT INFORMATION (Co			.1	
				Seed of Male of Freedo
Patient Name:				dender: Male Female
Address:			, State, ZIP Code:	Tracil (to areail areaided below)
Preferred Contact Methods: Phone				
Note: Carrier charges may apply. By pro				
emails and/or text messages from CVS				
requency varies. If unable to contact vi				
Email:				nguage:
Parent/Caregiver/Legal Guardian Namerescriber INFORMATION	ne (Last, First):	Re	elationship to patient:	
Prescriber's Name:	State	a Licanea i	#· NDI #·	DEA #·
Group or Hospital:			/·	
			state 7IP Code:	
ddress:Fax	Cont	act Persor	n.	Contact's Phone:
INSURANCE INFORMATION P	lease for early of prescriptic	on and inc	uranaa aarda with thia farm	if available (front and back)
				i, ii available (iforit and back)
DIAGNOSIS AND CLINICAL IN	IFORMATION (Attach c	opy of lat	os and clinical notes)	
leeds by Date: Ship to:	Patient U Office U Other:	:		
<u> Diagnosis (ICD-10):</u>	_			
B20 Human Immunodeficiency Viru				
B18.0 Chronic Viral Hepatitis B with	_		al Hepatitis B without Delta-	-Agent
B18.2 Chronic Viral Hepatitis C	R64 Ca	chexia		
Other Code: Description				
Patient Clinical Information:				
Allergies:		□ NKDA	Weight: lb/kg	Height: in/cm
reatment status: New to therapy	Continuation of therapy:	Date of las	st treatment//_	
D4 Count Baseline Viral load	Date of lab	s:		_
Cointection: I I None I I HCV I I HB	SV			
Coinfection: None HCV HB HLA-B*5701 test: Negative Pos				
HLA-B*5701 test: Negative Pos	sitive			.
ILA-B*5701 test: Negative Pos Iursing: pecialty Pharmacy to coordinate injec	itive ction training/home health r	nurse visit	as necessary?	□ No
ILA-B*5701 test: Negative Pos Iursing: pecialty Pharmacy to coordinate injectite of Care: MD office Infus	sitive ction training/home health r sion Clinic / Outpatient Heal	nurse visit i	as necessary?	□ No
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA

Prescriber Name: Prescriber Name: Preatment status: PRESCRIPTION INFORMA Ong-Acting Injectable: MEDICATION Dedicated Apretude Team Apretude 600 mg Injection Kit Apretude 600 mg	o therapy Continuation of therapy: DATION STRENGTH Phone Number: 1-855-801-8262 600 mg/3mL single-dose vial of cabotegravir 600 mg/3mL single-dose vial of cabotegravir Phone Number: 1-855-801-8262	Patient Phone: Prescriber Phone: ate of last treatment DOSE & DIRECTIONS Fax Number: 1-866-279-1993 Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	QUANTITY/REFILLS Quantity: 1 dosing kit Refills: 1 Quantity: 1 dosing kit
PRESCRIPTION INFORMATION INFORMATION MEDICATION Dedicated Apretude Team Apretude 600 mg Injection Kit Apretude 600 mg	STRENGTH Phone Number: 1-855-801-8262 600 mg/3mL single-dose vial of cabotegravir 600 mg/3mL single-dose vial of cabotegravir 7 Phone Number: 1-855-801-8262	DOSE & DIRECTIONS Fax Number: 1-866-279-1993 Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: 1
Dedicated Apretude Team Apretude 600 mg Injection Kit Apretude 600 mg	STRENGTH Phone Number: 1-855-801-8262 600 mg/3mL single-dose vial of cabotegravir 600 mg/3mL single-dose vial of cabotegravir n Phone Number: 1-855-801-8262	Fax Number: 1-866-279-1993 Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: 1
MEDICATION Dedicated Apretude Team Apretude 600 mg Injection Kit Apretude 600 mg	Phone Number: 1-855-801-8262 Good mg/3mL single-dose vial of cabotegravir Good mg/3mL single-dose vial of cabotegravir h Phone Number: 1-855-801-8262	Fax Number: 1-866-279-1993 Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: 1
Dedicated Apretude Team Apretude 600 mg Injection Kit Apretude 600 mg	Phone Number: 1-855-801-8262 Good mg/3mL single-dose vial of cabotegravir Good mg/3mL single-dose vial of cabotegravir h Phone Number: 1-855-801-8262	Fax Number: 1-866-279-1993 Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: 1
Injection Kit Apretude 600 mg	cabotegravir 600 mg/3mL single-dose vial of cabotegravir Phone Number: 1-855-801-8262	Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Refills: 1
	cabotegravir n Phone Number: 1-855-801-8262	Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit
		T N 1 4 000 0 T 0 4000	Refills:
	Dosing	Fax Number: 1-866-279-1993	
Option 1: Every-2-Month [
Cabenuva 600/900 mg	600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	Loading dose (Month 1 & Month 2): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle once monthly for 2 months then maintenance dose as directed	Quantity: 1 dosing kit Refills: 1
Cabenuva 600/900 mg	600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	Maintenance dose (Month 4+): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle every 2 months	Quantity: 1 dosing kit Refills:
Option 2: Every-1-Month [Dosing		
Cabenuva 600/900 mg	600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	Loading dose: Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle on day 1. Follow with maintenance dose in 1 month	Quantity: 1 dosing kit Refills: <u>0</u>
	400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	Maintenance dose: Inject 2 mL of cabotegravir and 2 mL of rilpivirine into the muscle every month	Quantity: 1 dosing kit Refills:
Dedicated Sunlenca Team	Phone Number: 1-877-602-5889	Fax Number:1-877-733-3199	
		Loading dose Option 1 927 mg by subcutaneous injection (2 x 1.5 mL injections) and 600 mg orally (2 x 300 mg tablets) on Day 1 Then 600 mg orally (2 x 300 mg tablets) on Day 2	Loading dose 1 Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: 0
Sunlenca	300 mg tablets 463.5 mg/1.5 mL vials	Loading dose Option 2 600 mg orally (2 x 300 mg tablets) on Day 1 600 mg orally (2 x 300 mg tablets) on Day 2 300 mg orally (1 x 300 mg tablet) on Day 8 Then 927 mg by subcutaneous injection (2 x 1.5 mL injections) on Day 15	Loading dose 2 Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials) Refills: 0
		Maintenance Dose 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection (+/-2 weeks).	Maintenance Quantity: (1) Injection dosing kit (contains 2 vials) Refills: 1
☐ Trogarzo	N/A	Please complete a Trogarzo Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at https://www.trogarzo.com/hcp/patient-support/ or by calling 1-833-23-THERA (1-833-238-4372). Fax enrollment form to 1-855-836-3069.	N/A
PRESCRIBER SIGNATURI	E REQUIRED (STAMP SIGNATURE NO	r ALLOWED)	
DAW / May Not Substitute Prescriber's Signature:	Date: ndated unless Prescriber writes the words "No Substitution"	Substitution Permissible Prescriber's Signature:	Date:

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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Alama Nian		-	nt and Prescriber Information	+ Discussion
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escriber Name		tion of theren	y: Date of last treatment/	
	ON INFORMATION	uon on unerap	y. Date of tast treatment/	
RTIs:	ON IN ORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Cimduo	☐ 300/300 mg			Quantity: Refills:
Lamivudine/				
Zidovudine*	□ 450/200 m s			Overtity Defiller
Brand no onger available	☐ 150/300 mg	Ш		Quantity: Refills:
or this drug				
Descovy	200/25 mg			Quantity: Refills:
Emtriva	200 mg			Quantity: Refills:
Epivir	☐ 150 mg ☐ 300 mg	<u> </u>		Quantity: Refills:
Abacavir/				
amivudine* Brand no	☐ 600/300 mg			Quantity: Refills:
onger available	□ 600/300 mg	<u> </u>		Quantity Remis
or this drug				
Retrovir	☐ 100 mg			Quantity: Refills:
Truvada	☐ 100/150 mg ☐ 133/200 mg			Quantity: Refills:
	☐ 167/250 mg ☐ 200/300 mg			
Viread	☐ 150 mg ☐ 200 mg ☐ 250 mg ☐ 300 mg	LJ		Quantity: Refills:
Abacavir*	☐ 250 mg ☐ 300 mg			
Brand no				Quantity: Refills:
onger available	☐ 300 mg			
or this drug				
Zidovudine	☐ 100 mg ☐ 300 mg	Ш		Quantity: Refills:
	•			
NDTIe•				
NRTIS: MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
	STRENGTH		DOSE & DIRECTIONS	
MEDICATION			DOSE & DIRECTIONS	QUANTITY/REFILLS
MEDICATION Edurant	☐ 25 mg		DOSE & DIRECTIONS	QUANTITY/REFILLS Quantity: Refills:
MEDICATION Edurant Efavirenz	☐ 25 mg ☐ 600 mg		DOSE & DIRECTIONS once daily with or without food	QUANTITY/REFILLS Quantity: Refills: Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg			QUANTITY/REFILLS Quantity: Refills: Ref
MEDICATION Edurant Efavirenz Intelence Pifeltro	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet	☐ Take o		QUANTITY/REFILLS Quantity: Refills: Re
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL	☐ Take o		QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Refills: Refills: Refills: Quantity: Refills: Refills
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL			QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg		once daily with or without food	QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Re
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR egrase Inhibitor IEDICATION	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg TS: STRENGTH			QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refi
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor Isentress	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg TS: STRENGTH ☐ 400 mg		once daily with or without food	QUANTITY/REFILLS Quantity: Refills:
MEDICATION Bedurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor MEDICATION	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg TS: STRENGTH		once daily with or without food	QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Refills: Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor Isentress Isentress HD	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg TS: STRENGTH ☐ 400 mg		once daily with or without food	QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Refills: Quantity: Quantity: Refills: Quantity: Quanti
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor MEDICATION Isentress Isentress HD	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg rs: STRENGTH ☐ 400 mg ☐ 600 mg		once daily with or without food	QUANTITY/REFILLS Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor MEDICATION Isentress Isentress HD Tivicay Tivicay PD	□ 25 mg □ 600 mg □ 25 mg □ 100 mg □ 200 mg □ 100mg tablet □ 50 mg □ 200 mg □ 200 mg □ 50 mg/ 5 mL □ 100 mg □ 400 mg □ 400 mg □ 600 mg □ 50 mg □ 5 mg		once daily with or without food	QUANTITY/REFILLS Quantity: Refills: Quantity: Qua
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR egrase Inhibitor Isentress Isentress HD Tivicay Tivicay PD Vocabria	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg STRENGTH ☐ 400 mg ☐ 600 mg ☐ 50 mg ☐ 50 mg	Take o	DOSE & DIRECTIONS	QUANTITY/REFILLS Quantity: Refills: Quantity: Quantity: Refills: Quantity: Quan
MEDICATION Bedurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor Isentress Isentress HD Tivicay Tivicay PD Vocabria Vedurant	25 mg	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV one: 1-844-588-3288; Fax 1-844-208-76	QUANTITY/REFILLS Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune XR Viramune XR IEDICATION Isentress Isentress HD Tivicay Tivicay PD Vocabria Vocabria	☐ 25 mg ☐ 600 mg ☐ 25 mg ☐ 100 mg ☐ 200 mg ☐ 100mg tablet ☐ 50 mg ☐ 200 mg ☐ 200 mg ☐ 50 mg/ 5 mL ☐ 100 mg ☐ 400 mg rs: STRENGTH ☐ 400 mg ☐ 600 mg ☐ 50 mg ☐ 5 mg N/A STRENGTH	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV	QUANTITY/REFILLS Quantity: Refills: Refills: Quantity: Qu
MEDICATION Edurant Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Egrase Inhibitor Isentress Isentress HD Tivicay Tivicay Vocabria Try Inhibitors: IEDICATION Fuzeon	□ 25 mg □ 600 mg □ 25 mg □ 100 mg □ 200 mg □ 100 mg □ 200 mg □ 200 mg □ 50 mg/ 5 mL □ 100 mg □ 400 mg □ 400 mg □ 600 mg □ 50 mg □ 5 mg N/A STRENGTH □ 90 mg vial	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV one: 1-844-588-3288; Fax 1-844-208-76	QUANTITY/REFILLS Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Refills: Refills: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Refills: Quantity: Refills: Refills: Refills: Quantity: Refills:
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Eegrase Inhibitor Isentress HD Tivicay Tivicay PD Vocabria Etry Inhibitors: MEDICATION Fuzeon Selzentry	25 mg	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV one: 1-844-588-3288; Fax 1-844-208-76	QUANTITY/REFILLS Quantity: Refills:
Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR tegrase Inhibitor Isentress HD Tivicay Tivicay PD Vocabria http://linhibitors: MEDICATION Fuzeon Selzentry	25 mg	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV one: 1-844-588-3288; Fax 1-844-208-76	QUANTITY/REFILLS Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Quantity: Refills: Refills: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Refills: Refills
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR Regrase Inhibitor Isentress Isentress HD Tivicay Tivicay PD Vocabria Retry Inhibitors: MEDICATION Fuzeon Selzentry PRESCRIBE	25 mg	Take o	DOSE & DIRECTIONS must be sent through the HUB, ViiV one: 1-844-588-3288; Fax 1-844-208-76 DOSE & DIRECTIONS IGNATURE NOT ALLOWED)	QUANTITY/REFILLS Quantity: Refills: Refills: Quantity: Refills: Refills: Quantity: Qu
MEDICATION Edurant Efavirenz Intelence Pifeltro Sustiva Viramune Viramune XR tegrase Inhibitor Isentress HD Tivicay Tivicay PD Vocabria try Inhibitors: MEDICATION Fuzeon Selzentry PRESCRIBE "Dispense As Writtet DAW / May Not Subs	25 mg	Take o	DOSE & DIRECTIONS May Substitute / Product Selection Substitution Permissible	QUANTITY/REFILLS Quantity: Refills: Quantity: Quantity: Refills: Quantity: Qua

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

	Please Co	mplete Patie <u>nt</u>	and Prescriber Inform	ation		
Patient Name:	Patient DOB: Patient Phone:					
Prescriber Name: _	Prescriber Phone:					
_	\square New to therapy \square Contin	uation of therapy:	Date of last treatment	_//		
PRESCRIPTION	INFORMATION					
Protease Inhibitors:						
MEDICATION	STREN	GTH	DOSE & DIREC			
Aptivus	250 mg 100 mg/mL		<u> </u>	Quantity: Refills:		
☐ Evotaz	☐ 300/150 mg		L	Quantity: Refills:		
☐ Kaletra	☐ 100/25 mg ☐ 200/50 m ☐ 80 mg – 20 mg/mL	g		Quantity: Refills:		
Fosamprenavir*				m		
*Brand no longer	☐ 700 mg		L	Quantity: Refills:		
available for this drug						
Norvir	☐ 100 mg ☐ 80 mg/mL		П	Quantity: Refills:		
Prezcobix	□ 800/150 mg			Quantity: Refills:		
		0		Quantity: Refills:		
Prezista	75 mg 150 mg 60					
∐ Reyataz —	150 mg 200 mg 30	0 mg	<u> </u>	Quantity: Refills:		
☐ Viracept	☐ 250 mg ☐ 625 mg		L	Quantity: Refills:		
ttachment Inhibitors						
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS		
Rukobia	600 mg Extended-Release			Quantity: Refills:		
harmacokinetic Enh	ancer:	1		<u> </u>		
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS		
☐ Tybost	☐ 150 mg			Quantity: Refills:		
letabolic Support:						
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS		
☐ Egrifta SV	N/A	Consent Form ar preferred pharm accessed at http 1-833-23-THERA	an Egrifta SV Patient Enrollm nd indicate CVS Specialty as y acy provider. The form may b s://hcp.egriftasv.com/ or by (1-833-238-4372). orm to 1-855-836-3069.	rour pe N/A		
Serostim	П			Quantity: Refills:		
upportive Therapy:	<u> </u>			+ according 100 100 100 100 100 100 100 100 100 10		
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS		
Bactrim	П			Quantity: Refills:		
_				Quantity: Refills:		
Diflucan	105		Lather the amount of the state of			
∐ Mytesi	125 mg tablet	☐ Take twice o	laily with or without food	Quantity: Refills:		
<u>ther:</u> MEDICATION	CTD	ENGTH	DOSE & DIRECTION	ONS QUANTITY/REFILLS		
Other:		ENGIII		Quantity: Refills:		
				Quantity: Refills:		
Other:			L	, , , , , , , , , , , , , , , , , , , ,		
Patient is interested in pat	ient support programs	STAMP SIGNATUR	E NOT ALLOWED Ancilla	y supplies and kits provided as needed for administration		
PRESCRIBER S	SIGNATURE REQUIRE	D (STAMP SIG	NATURE NOT ALLOV	VED)		
"Dispense As Written" / EDAW / May Not Substitut	Brand Medically Necessary / Do Not Su	abstitute / No Substitution		Selection Permitted /		

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