Publix Specialty Pharmacy #3213
HUMAN IMMUNODEFICIENCY VIRUS (HIV)

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
Address: ____ City: ____________________ State: _____________ Zip: _______________
Primary Phone Number: (____) _______________ Alt. Phone Number (____) ________________________ Caregiver name: __________________________

Clinical information [Attach copy of labs and office notes]

Diagnosis code: ________ ☐ HIV ☐ PrEP ☐ PEP Baseline Viral Load: _____________________ CD4 count: ____________ Date of Labs: ___/___/_____
Regimen status: ☐ New to regimen ☐ Continuation of regimen, start date: ___/___/___ Co-infections: ☐ None ☐ HCV ☐ HBV ☐ Other: __________________
Previously treated: ☐ No ☐ Yes, previous regimen ____________________________ SCr: _____ mg/dL, CrCl _______ mL/min, Date of SCr: ___/___/_____
Weight: _______ ☐ kg ☐ lb Height: _______ ☐ cm ☐ in Allergies: ☐ NKDA ☐ Other____

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/ DAYS	REFILLS
Single Tablet Regimens	☐ Biktarvy (BIC/FTC/TAF)	50/200/25 mg tablet	1 tab PO once daily with or without food	☐ 30 days ☐ 90 days	_______
	☐ Genvoya (EVG/COBI/FTC/TAF) ☐ Stribild (EVG/COBI/FTC/TDF)	150/150/200/10 mg tablet 150/150/200/300 mg tablet	1 tab PO once daily with food	☐ 30 days ☐ 90 days	_______
	☐ Triumeq (DTG/ABC/3TC)	50/600/300 mg tablet	1 tab PO once daily with or without food	☐ 30 days ☐ 90 days	_______
	☐ Dovato (DTG/3TC) ☐ Juluca (DTG/RPV)	50/300 mg tablet 50/25 mg tablet	1 tab PO once daily with or without food 1 tab PO once daily with food	☐ 30 days ☐ 90 days	_______
	☐ Atripla (EFV/FTC/TDF) ☐ Symfi (EFV/3TC/TDF) ☐ Symfi Lo (EFV/3TC/TDF)	600/200/300 mg tablet 600/300/300 mg tablet 400/300/300 mg tablet	1 tab PO QHS on an empty stomach	☐ 30 days ☐ 90 days	_______
	☐ Complera (RPV/FTC/TDF) ☐ Odefsey (RPV/FTC/TAF)	25/200/300 mg tablet 25/200/25 mg tablet	1 tab PO once daily with food	☐ 30 days ☐ 90 days	_______
	☐ Delstrigo (DOR/3TC/TDF)	100/300/300 mg tablet	1 tab PO once daily with or without food	☐ 30 days ☐ 90 days	_______
	☐ Symtuza (DRV/COBI/FTC/TAF)	800/150/200/10 mg tablet	1 tab PO once daily with food	☐ 30 days ☐ 90 days	_______
NRTI Combinations	☐ Cimduo (3TC/TDF) ☐ Descovy (FTC/TAF) ☐ Epzicom (3TC/ABC) ☐ Truvada (FTC/TDF)	300/300 mg tablet 200/25 mg tablet 300/600 mg tablet 200/300 mg tablet	1 tab PO once daily with or without food	☐ 30 days ☐ 90 days	_______
PI Combinations	☐ Evotaz (ATV/COBI) ☐ Prezcobix (DRV/COBI)	300/150 mg tablet 800/150 mg tablet	1 tab PO once daily with food	☐ 30 days ☐ 90 days	_______
	☐ Kaletra (LPV/RTV)	200/50 mg tablet	☐ 2 tabs PO BID with or without food ☐ 4 tabs PO once daily with or without food	☐ 30 days ☐ 90 days	_______
Other	☐ ________________________	____________________	__________________________________	_________	_______
	☐ ________________________	____________________	__________________________________	_________	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐ No ☐ Yes

Name: ____ DEA# ______________________ 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:

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(09-20)