

Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) Patient Name: Gender: Male Female City, State, ZIP Code: Address: Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: ___ ___ Alternate Phone: _ 2 PRESCRIBER INFORMATION Prescriber's Name: _____ State License #: _____ NPI #: _____ DEA #: _____ Group or Hospital: _____ City, State, ZIP Code: Address: Fax Contact Person: Contact's Phone: ____ Phone: INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) DIAGNOSIS AND CLINICAL INFORMATION (Attach copy of labs and clinical notes) Needs by Date: _____ Ship to: Patient Office Other: ____ Diagnosis (ICD-10): 🛾 B20 Human Immunodeficiency Virus (HIV) Disease 🔲 Z29.81 - Encounter for HIV pre-exposure prophylaxis B18.0 Chronic Viral Hepatitis B with Delta Agent 🔲 B18.1 Chronic Viral Hepatitis B without Delta-Agent R64 Cachexia B18.2 Chronic Viral Hepatitis C Other Code: _____ Description ___ Patient Clinical Information: _ NKDA Weight: _____lb/kg Height: _____ in/cm Treatment status: New to therapy Continuation of therapy: Date of last treatment ____/___/_ CD4 Count _____ Baseline Viral load_____ Date of labs: Coinfection: None HCV HBV HLA-B*5701 test: ☐ Negative ☐ Positive **Nursing:** Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No Site of Care: MD office Infusion Clinic / Outpatient Health Home Health 5 PRESCRIPTION INFORMATION Single Regimen Oral: **MEDICATION** STRENGTH **DOSE & DIRECTIONS QUANTITY/REFILLS** ☐ Biktarvy 50/200/25 mg Quantity: Refills: 200/25/300 mg Refills: ☐ Complera Quantity: П 100/300/300 mg Refills: Delstrigo Quantity: ☐ Dovato 50/300 mg Quantity: Refills: ☐ Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate* 600/200/300 mg Quantity: Refills: *Brand no longer available for this drug ☐ Genvoya 150/200/150/10 mg Ouantity: Refills: ☐ 50/25 mg Quantity: Refills: U Juluca Odefsey 200/25/25 mg Quantity: Refills: Stribild 150/150/200/300 mg Quantity: Refills: 600/300/300 mg Symfi Quantity: Refills: Symfi Lo 400/300/300 mg Quantity: Refills: 800/150/200/10 mg Quantity: Refills: Quantity: Refills: ☐ Triumeq 600/50/300 mg ☐ Triumeq PD 60/5/30 mg Refills: Quantity: 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: Prescriber's Signature: CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _ ATTN: New York and Iowa providers, please submit electronic prescription

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Phone: 1-800-237-2767

	Please Complete Patient, Prescrib Patient DOB:			
Patient Address:				
Prescriber Name:	Prescriber F therapy Continuation of therapy: Date	hone	e:	
Treatment status: New to PRESCRIPTION INFORM Long-Acting Injectable:	therapy Continuation of therapy: Date IATION	of las	st treatment//	
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
	n Phone Number: 1-855-801-8262	Fa	x Number: 1-866-279-1993	
Apretude 600 mg	600 mg/3mL single-dose vial of cabotegravir	Inje	Loading dose (Month 1 & Month 2): ect 3 mL into the muscle at month 1 and month then every 2 months thereafter	Quantity: 1 dosing kit Refills: 1
Apretude 600 mg	600 mg/3mL single-dose vial of cabotegravir		Maintenance dose (Month 4+): ect 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills:
Dedicated Cabenuva Tear	m Phone Number: 1-855-801-8262	Fa	x Number: 1-866-279-1993	
Option 1: Every-2-Month	Dosing			
Cabenuva 600/900 mg Injection Kit	600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	Inje inte	Loading dose (Month 1 & Month 2): ect 3 mL of cabotegravir and 3 mL of rilpivirine to the muscle once monthly for 2 months then aintenance 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	Inje	Maintenance dose (Month 4+): ect 3 mL of cabotegravir and 3 mL of rilpivirine to the muscle every 2 months	Quantity: 1 dosing kit Refills:
Option 2: Every-1-Month	Dosing		Lead to the second	T
Cabenuva 600/900 mg Injection Kit	600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	Inje inte	Loading dose: ect 3 mL of cabotegravir and 3 mL of rilpivirine to the muscle on day 1. Follow with maintenance se in 1 month	Quantity: 1 dosing kit Refills: <u>0</u>
Cabenuva 400/600 mg	400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	Inje	Maintenance dose: ect 2 mL of cabotegravir and 2 mL of rilpivirine to the muscle every month	Quantity: 1 dosing kit Refills:
Dedicated Sunlenca Team	n Phone Number: 1-877-602-5889	Fa	x Number:1-877-733-3199	
		927 inje	Loading dose Option 1 7 mg by subcutaneous injection (2 x 1.5 mL ections) and 600 mg orally (2 x 300 mg tablets) Day 1 en 600 mg orally (2 x 300 mg tablets) on Day 2	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	600 600 300 The	Loading dose Option 2 0 mg orally (2 x 300 mg tablets) on Day 1 0 mg orally (2 x 300 mg tablets) on Day 2 0 mg orally (1 x 300 mg tablet) on Day 8 en 927 mg by subcutaneous injection 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: O
		927	Maintenance Dose 7 mg by subcutaneous injection (2 x 1.5 mL ections) every 6 months (26 weeks) from the te of the last injection (+/-2 weeks).	Quantity: (1) Injection dosing kit (contains 2 vials) Refills: 1
☐ Trogarzo	N/A	Cor pre The http by	ase complete a Trogarzo Patient Enrollment and nsent form and indicate CVS Specialty as your aftered pharmacy provider. e form may be accessed at ps://www.trogarzo.com/hcp/patient-support/ or calling 1-833-23-THERA (1-833-238-4372).	N/A
PRESCRIBER SIGNATUR	RE REQUIRED (STAMP SIGNATURE NO	TAL	LOWED)	
DAW / May Not Substitute Prescriber's Signature:	dically Necessary / Do Not Substitute / No Substitution Date: andated unless Prescriber writes the words "No Substitution"		May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa providers, pleas	Date:e submit electronic prescription
, ,			pioriaoi 3, picas	procomption

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						Prescriber Informatio		
					3:	Patient Phone:		
atient Address: _ escriber Name:					rescriber Phon	o.		
eatment status:	New to	therapy	Continuation	n of the	apy: Date of la	e:		
PRESCRIPTION				01 (110)	apy. Date of ta	5t ti oddiiioint		
MEDICATION			STRENGTH			DOSE & DIRECTIONS		QUANTITY/REFILL
☐ Yeztugo			mg tablets .5 mg/1.5 mL vial	ls	take 2 tablets Injection kit:		ections)	Quantity: (4) 300 mg tablet (1) Injection dosin kit (contains 2 vials) Refills: 0
☐ Yeztugo		<u></u> 463	.5 mg/1.5 mL vial	ls		nce dose (Injection kit only): 5 mL injections) subcutaneo eeks)	usly every 6	Quantity: (1) Injection dosin kit (contains 2 vials) Refills:
RTIs:	1				•			•
MEDICATION			NGTH		DO	SE & DIRECTIONS		ANTITY/REFILLS
Cimduo	300/30	00 mg		$ \mid$ \cup			Quantity:	: Refills:
Lamivudine/ Zidovudine* *Brand no longer available	<u></u> 150/30	00 mg					Quantity:	: Refills:
for this drug Descovy	200/25	5 ma		$\dashv \sqcap$			Quantity	: Refills:
Emtriva	200 mg			ᅥᆸ			Quantity	
Epivir	☐ 150 mg	g [300 mg				Quantity	: Refills:
☐ Abacavir/ Lamivudine* *Brand no longer available for this drug	☐ 600/3d	00 mg					Quantity:	: Refills:
Retrovir	☐ 100 mg	r		$\dashv \sqcap$			Quantity	: Refills:
Truvada	100/15 167/25	0 mg	133/200 mg 200/300 mg					: Refills:
Viread	☐ 150 mg	_	200 mg 300 mg				Quantity:	: Refills:
Abacavir* *Brand no onger available for this drug	☐ 300 mį	g					Quantity:	: Refills:
Zidovudine	☐ 100 mg	g [300 mg				Quantity:	: Refills:
NRTIs:								
MEDICATION		STRE	NGTH		DO	SE & DIRECTIONS		NTITY/REFILLS
Edurant	25 mg						Quantity:	
_ Efavirenz	☐ 600 m	<u> </u>		_			Quantity:	
Intelence	25 mg		mg 200 mg	<u> </u>			Quantity:	
Pifeltro	☐ 100mg			ᆛ붜	ı ake once daily	with or without food	Quantity	
Sustiva	☐ 50 mg		O mg	- -			Quantity:	
Viramune	200 mg		mg/ 5 mL	- -			Quantity:	
Viramune XR		g <u> </u> 400		<u> </u>			Quantity:	: Refills:
PRESCRIBER	SIGNAT	JRE RE	QUIRED (ST	AMP S	IGNATURE N	OT ALLOWED)		
"Dispense As Writter DAW / May Not Subs Prescriber's Sig	stitute gnature:	-	essary / Do Not Subs	Dat	te:	May Substitute / Product Select Substitution Permissible Prescriber's Signature:		

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			and Prescriber Inforn	
		tient DOB:	Patient Ph	none:
tient Address: escriber Name:		Prescriber	Phone:	
	New to therapy Continuation	on of therapy: Date	of last treatment /	/
	N INFORMATION			
egrase Inhibitors:				
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Isentress	☐ 400 mg			Quantity: Refills:
] Isentress HD	☐ 600 mg			Quantity: Refills:
Tivicay	☐ 50 mg			Quantity: Refills:
Tivicay PD	☐ 5 mg			Quantity: Refills:
Vocabria	N/A		st be sent through the HUB, :: 1-844-588-3288; Fax 1-84	ΙΝΙΙΔ
try Inhibitors:				
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Selzentry	☐ 150 mg ☐ 300 mg	<u> </u>		Quantity: Refills:
otease Inhibitors:	STRENG	TL	DOSE & DIRE	CTIONS QUANTITY/REFILLS
Aptivus	☐ 250 mg ☐ 100 mg/mL			
Tevotaz	300/150 mg			Quantity: Refills: Quantity: Refills: R
Kaletra	☐ 100/25 mg ☐ 200/50 mg ☐ 80 mg – 20 mg/mL)		Quantity: Refills:
Fosamprenavir*				
Brand no longer vailable for this	☐ 700 mg			Quantity: Refills:
rug Norvir	☐ 100 mg ☐ 80 mg/mL		Ιπ	Quantity: Refills:
☐ Norvir ☐ Prezcobix	□ 800/150 mg			Quantity: Refills: Quantity: Refills:
) ma		Quantity: Refills:
_ Prezista	75 mg 150 mg 600			Quantity: Refills:
Reyataz	 _ 	ring		Quantity: Refills:
Viracept tachment Inhibito	250 mg 625 mg			QuartityNents
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Rukobia	600 mg Extended-Release	П		Quantity: Refills:
armacokinetic Enl				
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Tybost	☐ 150 mg			Quantity: Refills:
tabolic Support:				·
IEDICATION	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 Enrollid indicate CVS Specialty as acy provider. The form may s://hcp.egriftasv.com/ or by (1-833-238-4372).	your be N/A
Serostim				Quantity: Refills:
	IGNATURE REQUIRED (ST	AMP SIGNATU	RE NOT ALLOWED)	
	Brand Medically Necessary / Do Not Sub		ĺ	
	ature:	Date:		ature:Date:

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Prescriber Name:	ONS QUANT Quantity: Quantity:	
Patient Address:	ONS QUANT Quantity: Quantity:	TITY/REFILLS Refills: Refills:
Prescriber Name:	ONS QUANT Quantity: Quantity:	TITY/REFILLS Refills: Refills:
Treatment status: New to therapy Continuation of therapy: Date of last treatment PRESCRIPTION INFORMATION Supportive Therapy: MEDICATION STRENGTH DOSE & DIRECTI Bactrim Diflucan Diflucan Take twice daily with or without Other: MEDICATION STRENGTH DOSE & DIRECTI Bactrim Diflucan Diflucan Diflucan Diflucan Dose & Direction Diflucan Dose & Direction Dose & D	ONS QUANT Quantity: Quantity:	TITY/REFILLS Refills: Refills:
PRESCRIPTION INFORMATION Supportive Therapy: MEDICATION STRENGTH DOSE & DIRECTI Bactrim Difflucan Difflucan Take twice daily with or without Other: MEDICATION STRENGTH DOSE & DOSE & DIRECTI Take twice daily with or without DIRECTION STRENGTH DOSE &	ONS QUANT Quantity: Quantity:	Refills: Refills:
MEDICATION STRENGTH DOSE & DIRECTION Bactrim Difflucan Mytesi 125 mg tablet Take twice daily with or without Dither: MEDICATION STRENGTH DOSE & DIRECTION	Quantity:Quantity:	Refills: Refills:
MEDICATION STRENGTH DOSE & DIRECTION Bactrim	Quantity:Quantity:	Refills: Refills:
Bactrim Diflucan Mytesi 125 mg tablet Take twice daily with or withou Other: MEDICATION STRENGTH DOSE &	Quantity:Quantity:	Refills: Refills:
Diflucan Mytesi 125 mg tablet Take twice daily with or without The twice daily with or without	Quantity:	Refills:
Mytesi 125 mg tablet Take twice daily with or without the control of the control		
Other: MEDICATION STRENGTH DOSE &	t food Quantity:	Refills:
MEDICATION STRENGTH DOSE &		
☐ Other: ☐ ☐		TITY/REFILLS
	Quantity:	Refills:
Other:	Quantity:	Refills:
Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits provided as nee	eded for administration
_		
PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLO	WED)	
· · · · · · · · · · · · · · · · · · ·	te / Product Selection Permitted /	
DAW / May Not Substitute Substitution I		
Prescriber's Signature:Date: Prescribe	r's Signature:	Date:

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