Infectious Disease

Kroger specialty pharmacy

Garden Grove, CA **toll free** 800.228.3643 **toll free fax** 866.539.1092 **krogerspecialtypharmacy.com**

Date: _____ Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Male ☐ Female

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Drug Allergies	Weight ☐ kg ☐ lbs
Primary Diagnosis: ☐ B20 HIV/AIDS ☐ PREP; ICD-10: _____ ☐ PEP; ICD-10: _____	Comorbidities: ☐ B18.1 Hepatitis B (Chronic) ☐ B18.2 Hepatitis C (Chronic) ☐ R64: Cachexia (HIV Wasting) ☐ Other: _____
CD4 Cell Count / Viral Load/HIV RNA	CrCl / Date of Lab
Is Patient Currently on Therapy: ☐ No ☐ Yes	Has Patient Been Treated Previously for this Condition: ☐ No ☐ Yes If Yes, Medication: _____

Medication	Dose/Strength	Directions	Qty	Refills
Complete Regimens				
☐ ATRIPLA®	600mg-300mg-200mg Tablet	1 tablet by mouth once daily on empty stomach	_____	_____
☐ BIKTARVY®	50mg-25mg-200mg Tablet	1 tablet by mouth once daily	_____	_____
☐ CABENUEVA®	☐ Oral Lead-In (Theracom distributed) (carbotegravir 30mg Tablet/ rilpivirine 25mg Tablet)	1 tablet by mouth once daily with food/ 1 tablet by mouth once daily with food	30 30	None None
	☐ Initiation Injections (600-900mg)	2 injections intramuscular, once	1 Kit	None
	☐ Continuation Injections (400-600mg)	2 injections intramuscular, monthly	1 Kit	_____
☐ COMPLERA®	25mg-300mg-200mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ DELSTRIGO®	100mg-300mg-300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ DOVATO®	50mg-300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ GENVOYA®	150mg-150mg-10mg-200mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ JULUCA®	50mg-25mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ ODEFSEY®	25mg-25mg-200mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ STRIBILD®	150mg-150mg-300mg-200mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ SYMFI®	600mg-300mg-300mg Tablet	1 tablet by mouth once daily on empty stomach	_____	_____
☐ SYMFI LO®	400mg-300mg-300mg Tablet	1 tablet by mouth once daily on empty stomach	_____	_____
☐ SYMTUZA®	800mg-150mg-10mg-200mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ TRIUMEQ®	50mg-600mg-300mg Tablet	1 tablet by mouth once daily	_____	_____

_____ _____ _____ _____

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

Infectious Disease

Kroger specialty pharmacy
Garden Grove, CA **toll free** 800.228.3643 **toll free fax** 866.539.1092 **krogerspecialtypharmacy.com**

Date: _____ Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Male ☐ Female

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Drug Allergies	Weight ☐ kg ☐ lbs
Primary Diagnosis: ☐ B20 HIV/AIDS ☐ PREP; ICD-10: _____ ☐ PEP; ICD-10: _____	Comorbidities: ☐ B18.1 Hepatitis B (Chronic) ☐ B18.2 Hepatitis C (Chronic) ☐ R64: Cachexia (HIV Wasting) ☐ Other: _____
CD4 Cell Count / Viral Load/HIV RNA	CrCl / Date of Lab
Is Patient Currently on Therapy: ☐ No ☐ Yes	Has Patient Been Treated Previously for this Condition: ☐ No ☐ Yes If Yes, Medication: _____

Medication	Dose/Strength	Directions	Qty	Refills
NRTI				
☐ CIMDUO®	300mg-300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ COMBIVIR®	300mg-150mg Tablet	1 tablet by mouth twice daily	_____	_____
☐ DESCOVY®	25mg-200mg Tablet	1 tablet by mouth once daily	_____	_____
☐ EMTRIVA®	☐ 200mg Capsule ☐ 10mg/mL Soln	_____	_____	_____
☐ EPIVIR®	☐ 100mg Tablet ☐ 150mg Tablet ☐ 300mg Tablet ☐ 5mg/mL Soln ☐ 10mg/mL Soln	_____	_____	_____
☐ EPZICOM®	600mg-300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ RETROVIR®	☐ 100mg Tablet ☐ 300mg Tablet ☐ 10mg/mL Soln	_____	_____	_____
☐ TEMYXIS®	300mg-300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ TRUVADA®	☐ 300-200mg Tablet ☐ 250-167mg Tablet ☐ 200-133mg Tablet ☐ 150-100mg Tablet	1 tablet by mouth once daily	_____	_____
☐ VIREAD®	300mg Tablet	1 tablet by mouth once daily	_____	_____
☐ ZIAGEN®	300mg Tablet	☐ 1 tablet by mouth twice daily ☐ 2 tablets by mouth once daily	_____	_____
NNRTI				
☐ EDURANT®	25mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ INTELENCE®	☐ 25mg Tablet ☐ 100mg Tablet ☐ 200mg Tablet	_____	_____	_____
☐ PIFELTRO®	100mg Tablet	1 tablet by mouth once daily	_____	_____
☐ SUSTIVA®	☐ 50mg Tablet ☐ 200mg Tablet ☐ 600mg Tablet	1 tablet by mouth once daily on empty stomach	_____	_____
☐ VIRAMUNE®	☐ 200mg Tablet ☐ 50mg/5mL Soln	_____	_____	_____
☐ VIRAMUNE XR®	☐ 100mg Tablet ☐ 400mg Tablet	_____	_____	_____
Integrase Inhibitor				
☐ ISENTRESS®	☐ 400mg Tablet ☐ 600mg Tablet	_____	_____	_____
☐ TIVICAY®	50mg Tablet	☐ For naive: 1 tablet by mouth once daily ☐ For experienced: 1 tablet by mouth twice daily	_____	_____
Entry Inhibitor				
☐ FUZEON®	90mg/1mL Soln	1mL (90mg) under the skin twice daily	_____	_____
☐ RUKOBIA®	600mg Tablet	1 tablet by mouth twice daily	_____	_____
☐ SELZENTRY®	☐ 150mg Tablet ☐ 300mg Tablet	_____	_____	_____

_____ _____ _____ _____
Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

Infectious Disease

Garden Grove, CA **toll free** 800.228.3643 **toll free fax** 866.539.1092 **krogerspecialtypharmacy.com**

Date: _____ Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Male ☐ Female

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Drug Allergies		Weight ☐ kg ☐ lbs	
Primary Diagnosis: ☐ B20 HIV/AIDS ☐ PREP; ICD-10: _____ ☐ PEP; ICD-10: _____		Comorbidities: ☐ B18.1 Hepatitis B (Chronic) ☐ B18.2 Hepatitis C (Chronic) ☐ R64: Cachexia (HIV Wasting) ☐ Other: _____	
CD4 Cell Count	Viral Load/HIV RNA	CrCl	Date of Lab
Is Patient Currently on Therapy: ☐ No ☐ Yes		Has Patient Been Treated Previously for this Condition: ☐ No ☐ Yes If Yes, Medication: _____	

Medication	Dose/Strength	Directions	Qty	Refills
PK Booster				
☐ NORVIR®	☐ 100mg Tablet ☐ 80mg/mL Soln	_____	_____	_____
☐ TYBOST®	150mg Tablet	1 tablet by mouth once daily with food	_____	_____
Protease Inhibitors (PI)				
☐ APTIVUS®	☐ 250mg Capsule ☐ 100mg/mL Soln	_____	_____	_____
☐ CRIXIVAN®	☐ 400mg Capsule	☐ 2 capsules by mouth every 8 hours on empty stomach ☐ Take 2 capsules by mouth with NORVIR® twice daily	_____	_____
☐ EVOTAZ®	300mg-150mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ KALETRA®	☐ 100-25mg Tablet ☐ 200-50mg Tablet ☐ 80mg-20mg/mL Soln	_____	_____	_____
☐ LEXIVA®	☐ 700mg Tablet ☐ 50mg/mL Susp	_____	_____	_____
☐ PREZCOBIX®	800mg-150mg Tablet	1 tablet by mouth once daily with food	_____	_____
☐ PREZISTA®	☐ 75mg Tablet ☐ 150mg Tablet ☐ 600mg Tablet ☐ 800mg Tablet ☐ 100mg/mL Susp	_____	_____	_____
☐ REYATAZ®	☐ 150mg Capsule ☐ 200mg Capsule ☐ 300mg Capsule ☐ 50mg Packet	_____	_____	_____
☐ VIRACEPT®	☐ 250mg Capsule ☐ 625mg Capsule	_____	_____	_____
Growth Hormone				
☐ EGRIFTA SV®	2mg Vial	Inject 1.4mg under the skin once daily	30	_____
☐ SEROSTIM®	☐ 4mg Vial ☐ 5mg Vial ☐ 6mg Vial	Inject _____ mg under the skin once daily at bedtime	28	_____
Ancillary	☐ BD 3mL 20g x 1" Syringe ☐ 30g x 0.5" Needles	Use as directed with SEROSTIM®	QS	_____ _____
Other				

_____ _____ _____ _____

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date