



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____
Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____
Address _____ City _____ State _____ ZIP _____
Cell phone _____ Other phone _____ Email _____
Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____
Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____
Practice _____ Specialty _____
Address _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Office contact _____
Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Therapy for ☐ HIV treatment ☐ PrEP (prevention) ☐ PEP (after an exposure, 28 days)
Diagnosis (ICD-10) ☐ B20 HIV disease ☐ Z21 Asymptomatic HIV infection ☐ Z20.6 Exposure to HIV ☐ Other _____
Other conditions ☐ Hepatitis B ☐ Hepatitis C ☐ Kidney disease ☐ Pregnant ☐ Breastfeeding ☐ Other _____
Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____
Reason for switching _____
Viral load _____ copies/mL CD4 _____ cells/mm³ CrCl _____ mL/min Lab date _____
HLA-B*5701 ☐ Negative ☐ Positive ☐ Not tested Needed before abacavir HBsAg ☐ Negative ☐ Positive ☐ Unknown
For PrEP or PEP: date of last negative HIV test _____ Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy
Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

Medication	Strength	Directions	Quantity	Refills
Complete regimens				
☐ Biktarvy bictegravir / emtricitabine / tenofovir alafenamide	50/200/25 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Dovato dolutegravir / lamivudine	50/300 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Triumeq † abacavir / dolutegravir / lamivudine	600/50/300 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Genvoya elvitegravir / cobicistat / emtricitabine / tenofovir alafenamide	150/150/200/10 mg tab	1 tablet once daily with food	30 tablets	_____
☐ Odefsey emtricitabine / rilpivirine / tenofovir alafenamide	200/25/25 mg tab	1 tablet once daily with a meal	30 tablets	_____
☐ Symtuza darunavir / cobicistat / emtricitabine / tenofovir alafenamide	800/150/200/10 mg tab	1 tablet once daily with food	30 tablets	_____
☐ Juluca dolutegravir / rilpivirine	50/25 mg tab	1 tablet once daily with a meal	30 tablets	_____
☐ Delstrigo doravirine / lamivudine / tenofovir disoproxil fumarate	100/300/300 mg tab	1 tablet by mouth once daily	30 tablets	_____
Two-drug backbones, also used for PrEP and PEP				
☐ Descovy emtricitabine / tenofovir alafenamide	200/25 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Truvada or generic emtricitabine / tenofovir disoproxil fumarate	200/300 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Epzicom or generic † abacavir / lamivudine	600/300 mg tab	1 tablet by mouth once daily	30 tablets	_____
Other antiretrovirals and boosters				
☐ Tivicay dolutegravir	50 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Isentress raltegravir	400 mg tab	1 tablet by mouth twice daily	60 tablets	_____
☐ Isentress HD raltegravir	600 mg tab	2 tablets by mouth once daily	60 tablets	_____
☐ Prezcobix darunavir / cobicistat	800/150 mg tab	1 tablet once daily with food	30 tablets	_____
☐ Prezista darunavir (take with ritonavir 100 mg)	800 mg tab	1 tablet once daily with food	30 tablets	_____
☐ Evotaz atazanavir / cobicistat	300/150 mg tab	1 tablet once daily with food	30 tablets	_____
☐ Pifeltro doravirine	100 mg tab	1 tablet by mouth once daily	30 tablets	_____
☐ Edurant rilpivirine	25 mg tab	1 tablet once daily with a meal	30 tablets	_____
☐ Norvir or generic ritonavir (booster)	100 mg tab	1 tablet once daily with food	30 tablets	_____

Other medication (write in)

☐ _____
☐ _____

† Contains abacavir. Only for patients who test negative for HLA-B*5701.

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.