RARE SPECIALTY PHARMACY
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398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____
(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)
Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

IDC-10 Diagnosis Code: ❑B20 HIV/AIDS ❑R64 Cachexia (HIV Wasting) ❑B18.2 Hepatitis C (chronic) ❑B18.1 Hepatitis B
❑HIV-Infected patients with abdominal lipodystrophy ❑Other Diagnosis _____
CD4 Count: _____ Viral Load/HIV RNA: _____ Hbg/Hct: _____ WBC?ANC: _____ CrCl: _____ (please include a copy of most recent labs)
Has patient been on therapy and relapsed? ❑Yes ❑No List of medication(s) _____
Is patient currently on therapy? ❑Yes ❑No List of medication(s) _____
Will patient stop taking the medication(s) before or when starting the new medication? ❑Yes ❑No
List of medication(s) to be discontinued (Note: Fuzeon must be taken as part of a combination antiviral regimen)_____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

INFECTIOUS DISEASE ORDER FORM

❑**DESCOVY** 200mg/25mg QTY: _____
SIG: Refills: _____

COMBINATION ANTIRETROVIRALS

❑**ATRIPLA** 600/200/300mg	❑**DOVATO** 50/300mg	❑**STRIBILD** 150/150/200/300mg
❑**BIKTARVY** 50/200/25mg	❑**GENVOYA** 150/150/200/10mg	❑**SYMTUZA** 800/150/200/10mg
❑**COMPLERA** 200/25/300mg	❑**JULUCA** 50/25mg	❑**TRIUMEQ** 600/50/300mg
❑**DELSTRIGO** 100/300/300mg	❑**ODEFSEY** 200/25/25mg	❑**TRUVADA** 200/300mg

SIG: QTY: _____ Refills: _____

INTEGRASE INHIBITORS
❑**ISENTRESS** ❑400mg ❑600mg QTY: _____
❑**TIVICAY** 50mg Refills: _____
SIG:

FUSION INHIBITORS
❑**FUZEON** 90mg QTY: _____
SIG: Refills: _____

HEPATITIS B ORAL THERAPIES
BARACLUDE ❑0.5mg ❑1.0mg QTY: _____
❑ EPIVIR HBV 100mg ❑ HEPSERA 10mg Refills: _____
❑ VEMLIDY 25mg ❑ VIREAD 300mg
SIG:

XIFAXAN ❑200mg ❑550mg
❑ 1 200mg tab PO TID x 3 Days QTY: 9 Refills: _____
❑ 1 550mg tab PO BID QTY: 60 Refills: _____
❑ 1 550mg tab PO TID x 14 Days QTY: 42 Refills: _____
RELISTOR ❑8mg PFS ❑ 12mg PFS ❑ 150mg tablet QTY: _____ Refills: _____
SIG:

PRE-EXPOSURE PROPHYLAXIS (for HIV PrEP)
❑ **TRUVADA** 200/300mg tablet QTY: _____ Refills: _____
SIG: Take 1 tablet by mouth daily
❑ **DESCOVY** 200/25mg tablet QTY: _____ Refills: _____
SIG: Take 1 tablet by mouth daily

POST-EXPOSURE PROPHYLAXIS (for HIV PEP)
❑ **TRUVADA** 200/300mg tablet QTY: 28 Refills: _____
SIG: Take one tablet by mouth daily for four weeks
❑ **ISENTRESS** 400mg tablet QTY: 56 Refills: _____
SIG: Take one tablet by mouth twice daily for four weeks

❑**XERAVA** 50mg vial QTY: _____
SIG: Infuse _____ (1mg/kg dose) IV every 12 hours for _____days (4-14 days) Refills: _____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

❑ **SIVEXTRO** 200mg tablet
SIG: Take one tablet by mouth daily for 6 days QTY: 6 Refills: _____
❑ **BAXDELA** 450mg tablet QTY: _____ Refills: _____
SIG: Take one tablet by mouth twice daily for _____ days

❑ **BACTRIM** ❑ **DIFLUCAN** ❑ **SELZENTRY** QTY: _____
❑ **MEGACE** 40mg/mL ❑ **MEGACE ES** 625mg/5ml Refills: _____
SIG:

❑ **HARVONI** ledipasvir 90mg/sofosbuvir 400mg QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____
❑ **LEDIPASVIR** 90mg/sofosbuvir 400mg (generic) QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____

❑ **EPCLUSA** sofosbuvir 400mg/velpatasvir 100mg tablet QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____
❑ **SOFOSBUVIR** 400mg/velpatasvir 100mg tablet (generic) QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____

❑ **ZEPATIER** grazoprevir 100mg/elbasvir 50mg tablet QTY: 28
SIG: Take 1 tablet by mouth daily Refills: _____

❑ **VOSEVI** 400mg sofosbuvir/100mg velpatasvir/100mg voxilaprevir tablet QTY: 28
SIG: Take 1 tablet by mouth daily with food for 12 weeks Refills: 2

❑ **MAVYRET** 100mg glecaprevir/40mg pibrentasvir tablet QTY: 84
Therapy Length: ❑ 8 weeks or ❑ 12 weeks Refills: _____
SIG: Take 3 tablets by mouth once daily with food

❑ **RIBAVIRIN** ❑ 200mg cap ❑ 200mg tab Weight: _____kg QTY: _____
SIG: Refills: _____

❑ **SUNLENCA** ❑ 463.5mg/1.5ml SDV ❑ 300mg tablets QTY: _____
❑Starter: Day 1 take 600mg by mouth once, Inject 927mg SQ once. ❑vials
Day 2 take 600mg by mouth once. ❑tablets
❑Maintenance: Inject 927mg every 6 months (26 weeks from last injection) Refills: _____

❑ **TROGARZO** 200mg/1.33ml SDV QTY: _____ vials
❑Starter: Infuse 2g as a single dose. Refills: _____
❑Maintenance: Infuse 800mg every 14 days thereafter.

❑ **RUKOBIA** 600mg QTY: _____
SIG: Take 1 tablet (600mg) by mouth twice daily. Refills: _____

❑ **CABENUVA**
❑Starter: Cabenuva 600/900mg injection QTY: 1 kit
SIG: Inject into the muscle Cabotegravir 600mg and Rilpivirine 900mg once. Refills: 0
Begin Maintenance injections in 1 month.
❑Maintenance: Cabenuva 400/600mg injection QTY: 1 kit
SIG: Inject into the muscle Cabotegravir 400mg and Rilpivirine 600mg Refills: _____
monthly. May be given up to 7 days before or after the date of the scheduled
monthly injections.

OTHER:_____ SIG:_____ QTY:____ Refills:____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____Date: _____