



# Alternative Site Of Care (ASOC) Prescription Referral Form

Please contact ASOC to submit referral form directly

Prescriber should complete this prescription form. If you would like to submit an original prescription, please make sure it includes the required information listed below.

Intended ASOC Name:	Phone #:	Fax #:
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## 1. PATIENT INFORMATION (REQUIRED)

First Name:	Last Name:	MI:	Preferred Name:
Address:	Apt./Unit #:	City:	
State:	ZIP Code:	Phone #:	Date of Birth:

## 2. PRESCRIPTION INFORMATION (REQUIRED)

FOR PATIENTS ON YEZTUGO® (lenacapavir) (CHOOSE ONE OPTION ONLY)

### INITIATION (tablets/injections)

YEZTUGO **ORAL ONLY**  
NDC Number: 61958-3401-1  
Oral 300 mg tablet | QUANTITY: 4 | REFILLS: 0

YEZTUGO **INJECTION ONLY**  
NDC Number: 61958-3402-1  
Injection 927 mg | QUANTITY: 2 x 1.5 mLs | REFILLS: 1

### CONTINUATION (injections)

YEZTUGO **INJECTION ONLY**  
NDC Number: 61958-3402-1  
Injection 927 mg | QUANTITY: 2 x 1.5 mLs | REFILLS: 1

## 3. PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name:	Facility Name:	
Address:		
City:	State:	ZIP Code:
Office Contact:	Phone #:	
NPI #:	State License #:	

**CONFIDENTIAL HEALTHCARE INFORMATION:** I certify that I am the healthcare professional who has prescribed the therapy identified in this form and that the information on this form includes personal healthcare information related to the patient identified above. By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative, to the extent necessary under HIPAA and state law, or that such authorization is not required to release the individual's healthcare information, including that contained on this form, to the ASOC identified above. This information is being sent to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner and in compliance with applicable law. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **WARNING:** This message is intended for the use of the healthcare provider to whom it is addressed and may contain information that is confidential, the use and disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED.

**REQUIRED** PRESCRIBER SIGNATURE (REQUIRED): \_\_\_\_\_ DATE: \_\_\_\_\_  
(No stamped signature)