APRETUDE® (cabptegravir) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ every _____
☐ CMP ☐ At each dose ☐ every _____
☐ HIV-RNA ☐ At each dose ☐ every _____
☐ HIV Ab ☐ At each dose ☐ every _____
☐ LFT's to be drawn at 3rd dose and every 6 months

Required Labs: HIV-1 RNA and antibody within 7 days of each dose.
Liver function tests required at third dose and every six months.

APRETUDE THERAPY ADMINISTRATION

☐ 600 mg IM every month x 2 then every 2 months

☐ 600 mg IM every two months

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **HIV RNA and Antibody**
☐ **Liver Function Test**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (212) 776-9090
Email Referrals To: info@specialtyinfusion.com
Fax Referrals To: (800) 540-1852
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