APRETUDE
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (patient must weigh >35kg) **Allergies:** _____

Therapy Order

☐ **Apretude:** 600 mg IM every month x2 doses, then every 2 months thereafter (initial start) x1 year

OR

☐ **Apretude:** 600 mg IM every 2 months (maintenance dosing) x1 year

Lab Orders: HIV-1 RNA and antibody prior to each dose; LFTs at baseline, with 3rd dose and Q6 months

Other: _____

Labs: Required labs to be drawn by ☐ Infusion Center ☐ Referring Provider

Additional Orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

COMPREHENSIVE SUPPORT FOR APRETUDE THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis tried/failed medications

- ☐ Has the patient tried and failed an oral PrEP? ☐ Yes ☐ No
- ☐ Is the patient not a candidate for oral PrEP? ☐ Yes ☐ No

  If no, list reason: _____

- ☐ Provider attestation that patient demonstrates treatment readiness (i.e., ability to adhere to injection appointments, required labs, etc.)
- ☐ Is the patient taking an oral lead-in? ☐ Yes ☐ No

  If yes, initiate Apretude 1-month following the start of oral lead-in on the last day of the oral lead-in dose

☐ Labs attached **(HIV-1 RNA and antibody required, LFTs if available)**

☐ Patient enrolled in ViiVConnect (1-844-588-3288)

☐ Other Medical Necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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