

Patient Information **Demographics Attached**

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. (required) **Allergies:** _____

Clinical/progress notes, labs, tests supporting primary diagnosis attached
 HIV-1 RNA and antibody (required), LFTs (if available)
 Patient enrolled in ViiVConnect (1.844.588.3288)

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

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

Therapy Order

Apretude 600 mg IM every month x 2 doses, then every 2 months thereafter (initial start)

- OR -

Apretude 600 mg IM every 2 months (maintenance dosing)

Provider Information Orders are good for one year from the signature date.

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 _____

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