

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy

Next Treatment Date: _____

Diagnosis: _____ (ICD-10 Code: _____)

Demographics and Insurance Information -attached

Patient Weight: _____ lbs 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 Q6 months

MEDICATION ORDER

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

- OR -

Apretude 600mg IM every 2 months (maintenance dosing)

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Curbside Infusion Venture, LLC and its employees to serve as your prior authorization and Infusion Company designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ Signature: _____ Date: _____

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

Orders are good for one year from the signature date

Thank You For Your Referral

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