Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ HIV pre-exposure prophylaxis	ICD 10 Code: Z29.81
☐ Contact with and (suspected) exposure to human immunodeficiency virus (HIV)	ICD 10 Code: Z20.6
☐ High risk sexual behavior	ICD 10 Code: Z72.51
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Negative HIV-1 test

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Clinical/Progress notes (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment:

1)

2)

Is the patient currently taking oral cabotegravir? ☐ Yes ☐ No If Yes, Date started: _____

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

Initial Dosing	☐ J0739 Apretude 600mg IM monthly x 2 months
Maintenance Dosing	☐ J0739 Apretude 600mg IM every 2 months

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

Patient will need a negative HIV-1 test prior to each subsequent injection.

For gluteal IM injection only.

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
Ph. 217-258-4150
217-342-7500

Fax Completed Form and all documentation to: Fax 217-342-7499

INFUSION ORDERS - APRETUDE (CABOTEGRAVIR)

Clinics Scan to: Physician Orders