vitalcare® INFUSION SERVICES

Pharmacy Name: Vital Care Specialty
Address: 1501 23rd Ave Suite B
City/State/Zip: Meridian, MS 39301

Phone: 877-229-1724
Fax: 877-229-1725
Email: info@vitalcarerx.com

HIV Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

Last Name:	First Name:	DOB:	Practice:		
Address:			Address:		
City:	State:	Zip: Sex ☐ M ☐	City:	State:	Zip:
Phone:	SSN#		Prescriber Name:		
Insurance Information			Prescriber NPI:		
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:		
Policy #	Policy #		Phone:		
Plan I.D. #	Plan I.D. #		Fax:	Email:	

Diagnosis & Clinical Information

Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

Diagnosis code: _____

Diagnosis code: _____

Currently received and/or prior failed therapies: _____

_____

Length of treatment: _____

Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date: _____

Allergies: _____

_____

_____

☐ NKDA

Height: _____ Weight: _____

Site of Care: ☐ AIC ☐ Other: _____

Prescription Information

Prescription/Schedule	Medication	Quantity	Refills	Directions
Every-2-Month Dosing Cabenuva				
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	☐ 1 refill	**Month 1 & Month 2:** 2 injections intramuscularly
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	☐ PRN refills for 1 year *or* # of refills ____	**Month 4 +:** 2 injections intramuscularly, every 2 months
Once-Monthly Dosing Cabenuva and Apretude				
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	☐ None	2 injections intramuscularly, once
☐ CABENUVA 400-mg/600-mg kit	400-mg/600-mg kit: 400-mg single-dose vial of cabotegravir + 600-mg single-dose vial of rilpivirine	1 dosing kit	☐ PRN refills for 1 year *or* # of refills ____	2 injections intramuscularly, every month
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	☐ 1 refill	**Month 1 & Month 2:** 1 injection intramuscularly
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	☐ PRN refills for 1 year *or* # of refills ____	**Month 4 +:** 1 injection intramuscularly, every 2 months

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED