

HIV Referral Form

****Please Attach Copy of Insurance Cards (Front & Back)****

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: M F
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: _____

Allergies: _____

Length of treatment: _____

Reason for discontinuation: _____

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

☐ NKDA

Height: _____ Weight: _____

Site of Care:

☐ AIC

☐ Other: _____

Prescription Information

Prescription/Schedule	Medication	Quantity	Refills	Directions
Every-2-Month Dosing Cabenuva				
<input type="checkbox"/> 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	<input type="checkbox"/> 1 refill	Month 1 & Month 2: 2 injections intramuscularly
<input type="checkbox"/> 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	<input type="checkbox"/> PRN refills for 1 year or # of refills _____	Month 4 +: 2 injections intramuscularly, every 2 months
Once-Monthly Dosing Cabenuva and Apretude				
<input type="checkbox"/> 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	<input type="checkbox"/> None	2 injections intramuscularly, once
<input type="checkbox"/> 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	<input type="checkbox"/> PRN refills for 1 year or # of refills _____	2 injections intramuscularly, every month
<input type="checkbox"/> APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	<input type="checkbox"/> 1 refill	Month 1 & Month 2: 1 injection intramuscularly
<input type="checkbox"/> APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	<input type="checkbox"/> 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

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.