vitalcare® INFUSION SERVICES

Pharmacy Name: ______________ Phone: ______________
Address: ______________ Fax: ______________
City/State/Zip: ______________ Email: ______________

HIV Treatment and Prevention 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: ______________

☐ NKDA Height: ______ Weight: ______

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

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
☐ Patient has started Apretude via the Sample Program.	Date of next injection due ______________			

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

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