

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 |
| Phone: | SSN# | Prescriber Name: | |

Insurance Information

| | | |
|-----------------|-----------------|--------------------|
| Insurance Plan: | Insurance Plan: | Prescriber NPI: |
| Policy # | Policy # | Nurse/Key Contact: |
| Plan I.D. # | Plan I.D. # | Phone: |
| | | 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: _____

Site of Care: NKDA AIC Other: _____

Height: _____ Weight: _____

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 |
| <input type="checkbox"/> 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

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.