CURBSIDE INFUSION SERVICES

Apretude Injection Orders

P: 877.428.1627| **F:** 877.428.1627
Ext 0 -Scheduling- **Ext 1** Billing or fax referral to
referrals@curbsideinfusion.com

PATIENT INFORMATION

Patient Name: ________________ DOB: __________ Phone: __________

Patient Status: ☐ New to Therapy ☐ Continuing Therapy

Next Treatment Date:

Diagnosis: ________________ (ICD-10 Code:________)

☐ *Demographics and Insurance Information -attached*

Patient Weight: ________ lbs Allergies: ________________

☐ Clinical/progress notes, labs, tests supporting primary diagnosis attached

☐ HIV-1 RNA and antibody (required), LFTs (if available)

☐ Patient enrolled in ViiVConnect (1-844-588-3288)

Labs: Required labs to be drawn by ☐ Infusion Center ☐ Referring Provider

Lab Orders: HIV-1 RNA and antibody prior to each dose, LFTs at baseline, with 3rd dose, and Q6 months

MEDICATION ORDER

☐ Apretude 600mg IM every month x 2 doses, then every 2 months thereafter (initial start)

- OR -

☐ Apretude 600mg IM every 2 months (maintenance dosing)

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Curbside Infusion Venture, LLC and its employees to serve as your prior authorization and Infusion Company designated agent in dealing with medical and prescription insurance companies.

Provider Name: ________________ Signature: ________________ Date: __________

Provider NPI: __________ Phone: __________ Fax: __________ Contact Person: __________

Orders are good for one year from the signature date

Thank You For Your Referral

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