REVITALIZE
INFUSION CENTER

Apretude®

Infusion Order Form

Patient Information:

_____	_____	_____
Patient Name	**DOB**	**Phone Number**

Medical Information:

Primary Diagnosis:

☐ Contact with and suspected exposure to HIV	ICD-10 Code: Z20.6
☐ HIV Pre-exposure prophylaxis	ICD-10 Code: Z29.81
☐ High-risk sexual behavior	ICD-10 Code: Z72.5__
☐ Other_____	ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
- Relevant labs and tests including:
  - Negative HIV Test Results
- Medication List
  - If oral lead-in is to be used, injections should be initiated on the last day of oral lead-in or within 3 days. Oral lead-in therapy to be completed:_____

Height: _____

Weight: _____

Apretude (cabotegravir ER injection) Orders:

☐ **Loading Dose:** Administer 600 mg IM once monthly for two consecutive months to provide 2 doses

☐ **Maintenance Regimen:** Administer 600 mg IM once every two months for 12 months (7 doses)

☐ **Lab Orders:**_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____	_____
Prescriber's Signature	**Date**
_____	_____
Prescriber's Printed Name	**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize | Revitalize Locations | InfusionPlus