Apretude Injection Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864 7341

Patient Name: _____ **DOB:**_____

Patient Phone: _____ **SEX:** **M** ◯ **F** ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ Z29.91 HIV pre-exposure prophylaxis

◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

APRETUDE ORDER

Initial: ◯ Inject 600mg IM once monthly x 2 doses, then once every 2 months (+/- 7 days) x 1year

Maintenance: ◯ Inject 600mg IM once every 2 months (+/- 7 days) x 1 year

Date of last Apretude Injection: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____