BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

APRETUDE
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (patient must weigh >35kg)

Allergies: _____

THERAPY ORDER

☐ Apretude 600mg IM every month x 2 doses, then every 2 months thereafter (initial start) x1 year

- OR -

☐ Apretude 600mg IM every 2 months (maintenance dosing) x1 year

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

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

Additional orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Biocare Infusion, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR APRETUDE THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance informatio

☐ Include patient's medication list

☐ Supporting clinical notes (H&P) to support primary diagnosis including tried/failed medications

☐ Has the patient tried and failed an oral PrEP? ☐ Yes ☐ No

☐ Is the patient not a candidate for oral PrEP? ☐ Yes ☐ No

If no, list reason: _____

☐ Provider attestation that patient demonstrates treatment readiness (i.e., ability to adhere to injection appointments, required labs, etc.)

☐ Is the patient taking an oral lead-in? ☐ Yes ☐ No If yes, initiate Apretude 1-month following the start of oral lead-in on the last day of the oral lead-in dose

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

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

☐ Other medical necessity: _____

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance