

Patient Information

Patient Name:				DOB:		
Patient Phone:				Patient Email:		
NKDA	Allergies:			Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Last infusion date (if applicable): _____		
Is the patient pregnant, planning a pregnancy or nursing:			Yes	No	Does the patient need interpreter services: Yes No	

Provider Information

Referral Coordinator Name:				Referral Coordinator Email:		
Ordering Provider:				Provider NPI:		
Referring Practice Name:			Phone:	Fax:		
Practice Address:			City:	State:	Zip:	

ICD-10 CODE

Z11.4 Encounter for screening for human immunodeficiency virus Other: _____

Medication Order

Apretude (cabotegravir)	Dose: 600mg IM (gluteal)
	Initiation Therapy: Give first 2 doses 1 month apart for 2 consecutive months and then give every 2 months thereafter
	Maintenance Therapy: Give every 2 months
Oral Lead-In Therapy?	Yes Date of last dose of Oral Lead-In: _____
	No Date of desired first Apretude injection: _____
Labs	Negative infection status is confirmed (supply documentation).
Important Note: AleraCare requires Negative infection status confirmation prior to each administration. Please submit to the fax number above.	

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Negative HIV prior to each treatment) Insurance Card (front and back) Current Medications History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)_____
Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order

Patient Information

Patient Name:	DOB:	Sex:	M	F
Patient Phone:	Fasting:	Y	N	

Lab Test (Please circle or write in ICD-10)

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
CALCIUM	M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE	M81.0, M81.8, G35	PSA	R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD	M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE	E22, C7A.1, E34	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION	Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	
HIV 4TH GEN	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		
HIV 1/2 AB DIFF	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		

Frequency

Prior to each dose	Yearly	Other: Please Specify Below
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	

Provider Name

Provider Signature

Date

Provider Phone