VIVO infusion

Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.com
Have a Question? (855) 478-1528

APRETUDE® (CABOTEGRAVIR) REFERRAL

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

☐ New Referral ☐ Referral Renewal ☐ Medication/Treatment Change
☐ Benefits Verification Only ☐ Discontinuation Order

PATIENT INFORMATION

NAME*:	DOB*: SEX: ☐ M ☐ F
ADDRESS:	PHONE:
WEIGHT: ☐ LBS ☐ KG HEIGHT:	EMAIL:
ALLERGIES:	

PHYSICIAN INFORMATION

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE: FAX:	EMAIL *(FOR UPDATES)*:

APRETUDE Injection*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____
(required & specific as possible)

☐ **Initial Dosing:** 600mg IM every month x 2 doses, then every 2 months thereafter

☐ **Maintenance Dosing:** 600mg IM every 2 months

Physician Signature* _____ **Date*(Referral Valid for One Year)** _____

***NPI #** _____

Infusion will be administered per VIVO policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per VIVO policy and protocols)

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics Insurance
☐ Card/Information Progress
☐ Notes supporting DX Current
☐ Medication List and H&P
☐ HIV-1 RNA and antibody (required)
☐ Liver Function Tests (if available)

Required Labs:HIV-1 RNA and antibody prior to each dose, LFTs at baseline, with 3rd dose, and Q6 months to be sent to clinic

STANDING LAB REQUEST (to be drawn by clinic): ☐ CMP ☐ CBC *Frequency _____

Additional comments/notes:

Locations:

--------Colorado-------
☐ Lakewood

--------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

---------Ohio---------
☐ Beachwood
☐ Middleburg Hts.
☐ Painesville
☐ Youngstown
☐ Westlake
☐ Fairlawn

-------Oklahoma------
☐ Tulsa

---------Texas---------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 5/2022