

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> HIV pre-exposure prophylaxis	ICD 10 Code: Z29.81	
<input type="checkbox"/> Contact with and (suspected) exposure to human immunodeficiency virus (HIV)	ICD 10 Code: Z20.6	
<input type="checkbox"/> High risk sexual behavior	ICD 10 Code: Z72.51	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Negative HIV -1 test	
List tried and failed therapies including duration of treatment:		
1) _____		
2) _____		
3) _____		
Is patient currently taking oral cabotegravir <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date started: _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders		
Initial Dosing	<input type="checkbox"/> J0739 Apretude 600mg IM monthly x2 months	
Maintenance Dosing	<input type="checkbox"/> J0739 Apretude 600mg IM every 2 months	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
ADDITIONAL ORDERS/ INFORMAITON		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515  
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS –APRETUDE (CABOTEGRAVIR)**