

APRETUDE REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:		
DATE OF REFERRAL:	ADDRESS:		
DATE OF BIRTH:	CITY, STATE, ZIP:		
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:			
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE		MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST		NKDA

PRIMARY DIAGNOSIS:

Z20.6 - Contact with and (suspected) exposure to HIV	Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission	
Z11.4 - Encounter for screening for human immunodeficiency virus (HIV)	Z20.2 - Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	
Z20.5 - Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission	Z20.6 - Contact with and (suspected) exposure to HIV	
Z51.81 - Encounter for therapeutic drug-level monitoring	Z72.51 - High-risk heterosexual behavior	Z72.52 - High-risk homosexual behavior
Z72.53 - High-risk bisexual behavior	Z79.899 - Other long-term (current) drug therapy	Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back)	<input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS	<input checked="" type="checkbox"/> 3. MOST RECENT LABS	<input checked="" type="checkbox"/> 4. MEDICATION LIST
<input checked="" type="checkbox"/> 5. H & P			
<input checked="" type="checkbox"/> 6. DOCUMENTATION OF ALL PREVIOUSLY ATTEMPTED THERAPIES			
<input checked="" type="checkbox"/> Has the patient tested NEGATIVE for HIV? (Provide documentation)		Y	N
Result Date:			

PRIMARY MEDICATION ORDER:

PRN & PREMEDICATIONS:

<p>Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.</p> <p><u>If using oral lead-in:</u> Apretude 600 mg IM injection on the last day of oral lead-in (or within 3 days thereafter), at week 4, and every 8 weeks thereafter. <i>*Oral lead-in to be prescribed and managed by referring provider</i></p> <p><u>If there is no oral lead-in:</u> Apretude 600 mg IM injection at week 0, 4, and every 8 weeks thereafter.</p> <p>Other: _____</p> <p>FIRST DOSE: Y N</p> <p><input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.</p>	MEDICATIONS	30 minutes prior to every injection	PRN
	Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate injection reaction.
	Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate injection reaction.
	Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate injection reaction.
	Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate injection reaction.
Other: _____		PRN every ___ hour for mild or moderate injection reaction.	

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
<input checked="" type="checkbox"/> START PIV/ACCESS CVC (As Needed for ADVERSE REACTIONS)
OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

(GENERIC SUBSTITUTION PERMITTED)
 PROVIDER SIGNATURE: _____ DATE: _____

(DISPENSE AS WRITTEN)
 PROVIDER SIGNATURE: _____ DATE: _____

APRETUDE REFERRAL FORM

FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INJECTION REACTION	MODERATE INJECTION REACTION	SEVERE INJECTION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.