Cabotegravir (Apretude)

Provider Order Form rev. 12/19/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

HIV PrEP:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: administer Cabotegravir (Apretude) 600mg IM every 1 month for 2 months as gluteal injection *(begin on last day of oral lead in. Oral lead in for 1 month recommended but not required)*

☐ Maintenance: administer Cabotegravir (Apretude) 600mg IM every 2 months as gluteal injection

☑ Medication can be given up to 7 days prior to next scheduled dose

ADDITIONAL ORDERS

NURSING

☑ Hold infusion and notify provider for:

- Positive HIV-1 test
- Hepatotoxicity
- Severe depressive disorder
- Unknown HIV-1 status
- Patients weighing less than 35kg
- Lack of compliance

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

PRE-MEDICATION ORDERS

☐ Other: _____

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.