

APRETUDE (CABOTEGRAVIR) PRESCRIBER ORDER FORM

Patient Name:		Date of Birth:	Gender:	
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
If New to Therapy, will patient be started on oral lead-in of Vocabria (cabotegravir)? <input type="checkbox"/> No <input type="checkbox"/> Yes- recommend oral lead-in should NOT be started until any applicable Apretude payor authorization has been secured	
If Yes, has patient started oral lead-in of Vocabria (cabotegravir)? <input type="checkbox"/> No – Upon securing applicable prior authorization, Option Care Health will follow-up with prescriber to coordinate oral lead-in <input type="checkbox"/> Yes – Start Date: _____	
If Continuing Therapy, date of last injection (if known): _____ Date of next injection: _____	

Apretude (Cabotegravir) Prescription

Apretude (Cabotegravir)

Initiation Doses: Nurse to administer cabotegravir 600 mg via intramuscular injection monthly x 2 months. If oral lead-in is used, injection should be administered on the last day of oral lead-in (28 days) or within 3 days thereafter. Discontinue oral lead-in after Apretude administration. Dispense Apretude 600 mg kit x 1 dose with refills x 1

Maintenance Dose: Nurse to administer cabotegravir 600 mg via intramuscular injection every 2 months (+/- 7 days to allow for patient/nurse scheduling) beginning 2 months after completion of initiation doses. Dispense Apretude 600 mg kit x 1 dose with refills x 1 year.

NOTE: Individuals must be tested for HIV-1 infection prior to initiating Apretude and with each subsequent injection of Apretude.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
 Yes No

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders
 Other: _____

Lab Orders
 No labs ordered at this time
 Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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