APRETUDE (CABOTEGRAVIR) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: **ICD-10 Code:**

If New to Therapy, will patient be started on oral lead-in of Vocabria (cabotegravir)?

☐ No ☐ 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)?

☐ No – Upon securing applicable prior authorization, Option Care Health will follow-up with prescriber to coordinate oral lead-in

☐ 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:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

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