Apretude (Cabotegravir) Prescriber Order Form

Fax completed form, insurance information, and clinical documentation to:

option care health

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

Clinical Information

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

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: _____

Apretude (Cabotegravir) Prescription

Apretude (Cabotegravir)

☐ Initial Dose: 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). 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. Option Care Health will only accept an RNA-specific assay results within 7 days prior to administration.**

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- please complete the Anaphylaxis Physician Order (FR-PC-036) ☐ No

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.

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:**	

