


# Apretude (CABOTEGRAVIR) PRESCRIBER ORDER FORM

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

 option care health™	<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____		
	<b>Address:</b> _____			
<b>Phone:</b> _____	<b>Height:</b> _____	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b> _____	<input type="checkbox"/> lbs <input type="checkbox"/> kg

## Clinical Information

<b>Primary Diagnosis Description:</b> _____	<b>ICD-10 Code:</b> _____
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**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 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> 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

<b>Prescriber Name:</b> _____	<b>Phone:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>NPI:</b> _____	
<b>City, State:</b> _____	<b>Zip:</b> _____	<b>Office Contact:</b> _____

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