

APRETUDE (CABOTEGRAVIR) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

DIAGNOSIS (Provider must specify)

PrEP to reduce the risk of sexually acquired HIV-1 infection in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition, ICD 10: Z29.81
 Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Apretude	600 mg injection given 1 month apart for 2 consecutive months on the last day of an oral lead-in if used or within 3 days and continue with the injections every 2 months thereafter	IM

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

CT: 203.433.0621
 FL: 904.877.9270

MA: 413.296.8482
 MD: 240.224.8607
 ME: 207.407.7272

NC: 919.984.8698
 NH: 603.217.5371
 NJ: 201.581.4521

NY: 631.250.6020
 OH: 937.871.4594
 PA: 610.273.5998

SC: 864.973.6279
 VA: 703.202.0499