INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

# Apretude *cabotegravir extended-release injectable suspension*

## PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

## 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) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

## PREREQUISITES TO TREATMENT

*Ensure the following is complete and attached with the referral*

☐ Individuals must have a negative HIV-1 test prior to initiating (with or without an oral lead-in with oral cabotegravir) for HIV-1 PrEP

## PRE-MEDICATION

*Not typically indicated*

☐ Acetaminophen (Tylenol) 500 mg PO

☐ Famotidine 20 mg IV

☐ Methylprednisolone (Solu-Medrol) 125 mg IVP

☐ Diphenhydramine (Benadryl) 25 mg PO

☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

## MEDICATION ORDER

| 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, then continue with injections every 2 months thereafter | IM |

## LABS / SPECIAL INSTRUCTIONS

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