

# Cabotegravir (Apretude)

Provider Order Form rev. 03/17/2026

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_  
Sex:  M /  F Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

## DIAGNOSIS (Please provide ICD-10 code in space provided)

HIV PrEP: \_\_\_\_\_  
Other: \_\_\_\_\_ Description: \_\_\_\_\_

## THERAPY ADMINISTRATION & DOSING

- Induction and Maintenance: administer Cabotegravir (Apretude) 600mg IM every 1 month for 2 months as gluteal injection. Then administer Cabotegravir (Apretude) 600mg IM every 2 months as gluteal injection (*begin on last day of oral lead in. Oral lead in for 1 month recommended but not required*)
- Maintenance Only: administer Cabotegravir (Apretude) 600mg IM every 2 months as gluteal injection
- Medication can be given up to 7 days prior to next scheduled dose

## PRE-MEDICATION ORDERS

Other: \_\_\_\_\_

## ADDITIONAL ORDERS

## REQUIRED LABORATORY ORDERS

HIV-1 RNA within 7 days prior to each dose, results must be available and reviewed before injecting. HIV-1 RNA order to be managed by referring office

## NURSING

- Hold infusion and notify provider for:
- Positive HIV-1 test
  - Hepatotoxicity
  - Severe depressive disorder
  - Unknown HIV-1 status
  - Patients weighing less than 35kg
  - Lack of compliance
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

## PROVIDER INFORMATION

Preferred Contact Name: \_\_\_\_\_ Preferred Contact Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name (print)

Provider Signature

Date