

Apretude (cabotegravir)

Provider Order Form rev. 8/20/2022



www.aleracare.com

ph: (602) 346-0204 fax: (877) 637-6691

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

NKDA Allergies: _____ Weight lbs/kg: _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

Z11.4 Encounter for screening for human immunodeficiency virus

Other: _____

MEDICATION ORDER

Apretude (cabotegravir)

Dose: 600mg IM (gluteal)

Initiation Therapy: Give first 2 doses 1 month apart for 2 consecutive months and then give every 2 months thereafter

Maintenance Therapy: Give every 2 months

SPECIAL INSTRUCTIONS

Oral Lead-In Therapy?

Yes → Date of last dose of Oral Lead-In: _____

No → Date of desired first Apretude injection: _____

Yes - once coverage for drug is determined (AleraCare to coordinate with office)

Labs

Negative infection status is confirmed (supply documentation). **Important Note:** AleraCare requires Negative infection status confirmation **prior to each** administration. Please submit to the fax number above.

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order