aleracare
advanced infusion centers™

FAX 833.329.4738

Apretude (cabotegravir)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

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

Oral Lead-In Therapy? ◯ Yes Date of last dose of Oral Lead-In:_____

◯ No Date of desired first Apretude injection:_____

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.

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (Negatuve HIV prior to each treatment) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯