# Apretude (Cabotegravir) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
**Fax completed form, insurance information and clinical documentation to 414-260-7368.**

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________

Phone: ______________________ Height: __________ ☐ inches ☐ cm Weight: __________ ☐ lbs ☐ kg

## Clinical Information

Primary Diagnosis Description: ______________________ ICD-10 Code(s): __________

**Will patient be started on oral lead-in of Vocabria (cabotegravir)?**

☐ No ☐ Yes - recommend oral lead-in should **NOT** be started until any applicable Apretude payor authorization has been secured.

**If yes, has patient started oral lead-in of Vocabria (cabotegravir)?**

☐ No – Upon securing applicable prior authorization, Froedtert Home and Specialty Infusion will follow-up with prescriber to coordinate oral lead-in.

☐ Yes – Start Date: __________

## Apretude (Cabotegravir) Prescription

**Apretude (Cabotegravir)**

☐ **Initial Dose:** __Initiation Doses:__ Nurse to administer cabotegravir 600 mg via intramuscular injection monthly x 2 months. If oral lead-in is used, injection should be administered on the last day of oral lead-in (28 days) or within 3 days thereafter. Discontinue oral lead-in after Apretude injection administration. Dispense Apretude 600 mg kit x 1 dose with refills x 1

☐ **Maintenance Dose:** __Maintenance Dose:__ Nurse to administer cabotegravir 600 mg via intramuscular injection every 2 months (+/– 7 days to allow for patient/nurse scheduling) beginning 2 months after completion of initiation doses. Dispense Apretude 600 mg kit x 1 dose with refills x 1 year.

**NOTE: Individuals must be tested for HIV-1 infection prior to initiating Apretude and with each subsequent injection of Apretude. Froedtert Home and Specialty Infusion will only accept RNA-specific assay results within 7 days prior to administration.**

## Ancillary Orders

**Anaphylaxis Kit**

☐ Treat per Froedtert Home and Specialty Infusion protocol.

**Pre-Medication Orders**

☐ Other: ______________________

**Lab Orders**

☐ No labs ordered at this time.
☐ Other: ______________________

**Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.**

**I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.**

______________________ Prescriber Signature | __________ Date | __________ Time

______________________ Prescriber Name | __________ Phone | __________ Fax

______________________ Address | __________ NPI

______________________ City, State, Zip | __________ Office Contact

Froedtert Home and Specialty Infusion
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