APRETUDE
(cabotegravir)

InfuseAble Care | FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Negative HIV Test Date: _____

PRIMARY DIAGNOSIS

☐ Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
☐ Z11.4 Encounter for screening for human immunodeficiency virus (HIV)
☐ Z20.5 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High-risk heterosexual behavior
☐ Z72.52 High-risk homosexual behavior
☐ Z72.53 High-risk bisexual behavior
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Apretude
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ IF OPTIONAL ORAL LEAD-IN: Apretude 600mg IM monthly x 2 months, starting on the last day of oral lead-in (or within 3 days thereafter), followed by Apretude 600mg IM every 2 months thereafter.
*Oral lead-in to be prescribed and managed by referring provider. Start Date: _____
☐ IF NO ORAL LEAD-IN: Apretude 600 IM monthly x 2 months, followed by Apretude 600mg IM every 2 months thereafter.
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (480) 400-6121 | EMAIL: referral@infuseablecare.com | VISIT: infuseablecare.com/provider-services/order-forms