Apretude (cabotegravir)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ Z29.81 Encounter for human immunodeficiency virus (HIV) pre-exposure prophylaxis
☐ Z01.812 Encounter for preprocedural laboratory examination
☐ Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
☐ Z11.4 Encounter for screening for HIV
☐ Z11.59 Encounter for screening for other viral diseases
☐ Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
☐ Z20.5 Contact with and (suspected) exposure to viral hepatitis
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z51.81 Encounter for therapeutic drug-level monitoring
☐ Z72.51 High-risk heterosexual behavior
☐ Z72.52 High-risk homosexual behavior
☐ Z72.53 High-risk bisexual behavior
☐ Z79.899 Other long-term (current) drug therapy
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☑ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

No recommended standard pre-meds for Apretude
☐ Provider Prescribed: _____
Dose: _____ Route: _____

Lab Orders

*Required: Negative HIV Test Date:*_____
☐ Other: _____

Apretude Medication: (Select one):

Loading Dose:

☐ 600 mg injected intramuscularly once every 2 months.
☐ Other: _____

Maintenance Dose:

☐ 600 mg injected intramuscularly every 2 months, beginning 2 months after completion of initiation doses.
☐ Other: _____

Special Instructions: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ for 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**