Apretude (cabotegravir)

Provider Order Form rev. 8/20/2022

VASCO INFUSION
www.vascoinfusion.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: _____

SPECIAL INSTRUCTIONS

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.

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**