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Suite 120
Troy, OH 45373
Phone: 937-401-6620
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
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Apretude® (cabotegravir) Order Form

Patient Name: ____**DOB:** _________________

Address: ____

Phone: ____ **ICD-10 Diagnosis:** _______

Will patient be started on oral lead-in of Vocabria (cabotegravir)?
☐No ☐ Yes *recommended 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?
☐No ☐ Yes – Start date __________

Induction Dosing:
☐ Apretude 600mg IM monthly x 2 **started within 3 days of last day of oral lead-in treatment if applicable.

Maintenance Dosing:
☐ Apretude 600mg IM every 2 months (+/- 7 days)

Order good for: ☐ 6 months ☐ 1 year Other duration: ________________________

Lab requirements (please fax results if available):

- HIV-1 RNA assay ≤7 days prior to each Apretude dose (must be resulted prior to scheduled appointment)
- Baseline & periodic liver function tests

Lab Orders: ____

Lab Frequency: ____

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: _____________________ **Office Fax Number:** _____________________

Prescriber Signature: ________________________________ **Date:** _______________