Cabotegravir (Apretude)

Provider Order Form rev. 03/17/2026

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

HIV PrEP:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction and Maintenance: administer Cabotegravir (Apretude) 600mg IM every 1 month for 2 months as gluteal injection. Then administer Cabotegravir (Apretude) 600mg IM every 2 months as gluteal injection. *(begin on last day of oral lead in. Oral lead in for 1 month recommended but not required)*

☐ Maintenance Only: administer Cabotegravir (Apretude) 600mg IM every 2 months as gluteal injection

☑ Medication can be given up to 7 days prior to next scheduled dose

PRE-MEDICATION ORDERS

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ HIV-1 RNA within 7 days prior to each dose, results must be available and reviewed before injecting.

☐ HIV-1 RNA order to be managed by referring office

☐ HIV-1 RNA order to be managed by Novella Infusion.

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Positive HIV-1 test
- Hepatotoxicity
- Severe depressive disorder
- Unknown HIV-1 status
- Patients weighing less than 35kg
- Lack of compliance

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.