Phone: (833) 394-0600 Fax: (833) 996-4888

Apretude Injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: __________________________________ **Patient Weight:** __________lbs / kg **Height:**_____________

ICD-10 : __________________________, ______________________________, _________________________

What medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use	Reason for discontinuation

Date of negative HIV-1 RNA and antibody prior to initiation of treatment___________________ (please attach results)

Negative HIV-1 RNA and antibody test required WITHIN 7 days of EVERY injection

Apretude (cabotegravir extended release) Intramuscular injection

☐ **600mg monthly x 2 doses then every 2 months thereafter**

☐ **600mg Every 2 months**

Date of last injection if applicable: ___________________________

Printed Provider Name: ____

Provider Signature: ____

Office Phone Number: ________________________**Office Fax Number:** _________________________________

Contact Name: ___________________________**Contact Phone Number:** _________________________________

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: ________