

Apretude Order

(cabotegravir)

SMART CHOICE INFUSION

FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com

Ph: 818-659-8182

Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics ☐ Current Lab Results (within 30 days)
☐ H & P Relevant to the Diagnosis ☐ Medication List ☐ HIV-1 Test
☐ Copy of Insurance Cards

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

APRETUDE (cabotegravir) Injection Dosage: 600 mg/3 mL ER Intramuscular (Gluteal) Injection Suspension

- ☐ Initiation with Oral Lead-In: Month 2 and Month 3 / Continuation: Month 5 and every 2 months thereafter
☐ Initiation Direct to Injection: Month 1 and Month 2 / Continuation: Month 4 and every 2 month thereafter
☐ Continuation: Every 2 months

May be given 7 days before or after scheduled injection