

APRETUDE® (cabptegravir) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:
		Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

☒ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC	At each dose	every _____
CMP	At each dose	every _____
HIV-RNA	At each dose	every _____
HIV Ab	At each dose	every _____

LFT's to be drawn at 3rd dose and every 6 months

Required Labs: HIV-1 RNA and antibody within 7 days of each dose.
Liver function tests required at third dose and every six months.

APRETUDE THERAPY ADMINISTRATION

600 mg IM every month x 2 then every 2 months (+/- 7 days)

600 mg IM every two months (+/- 7 days)

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

HIV RNA and Antibody

Liver Function Test

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

Provider Name (Print)

Provider Signature

Date

Fax Numbers

Colorado: 303-418-4679	Nevada: 702-489-5744	Oklahoma: 918-770-4421
Connecticut: 203-724-4838	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	New York: 800-540-1852	Texas: 469-340-0044
Massachusetts: 800-540-1852	Ohio: 216-400-0674	Virginia: 804-500-5941

Revision Date 6/2024