ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Cabotegravir (Apretude®)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis: ❑ HIV preexposure prophylaxis ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

❑ HIV-1 (HIV Ag/Ab and HIV 1 RNA) within 7 days before injection
❑ STI
❑ Hep B (surface Ab, core Ab, surface antigen)
❑ Hep C (prior history = C RNA quantittive, no history = Ab screen)
*STI=GC/CT NAAT (urine, throat/rectal swab); Syphilis (prior hx=RPR for therapeutic response, no hx=Syphilis total Ab reflex)

Maintenance labs:

❑ HIV-1 within 7 days before injection
❑ STI

****Individuals who acquire HIV-1 while receiving Cabotegravir for PrEP must transition to a complete HIV-1 treatment regimen.**

Prophylaxis Treatment Regimen:

❑ Cabotegravir (Apretude®) 600 mg IM every 28 days x2 doses initially followed by 600 mg IM every 56 days (start 3rd injection 56 days from 2nd injection)

Administer in the ventrogulated site. A dorsogluteal approach (upper outer quadrant) is acceptable. Do not administer by an other route or anatomical site. May be given up to 7 days before or after the date the individual is scheduled to receive the injections.

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact primary care provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify primary care provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
HIV PREEXPOSURE PROPHYLAXIS

MultiCare

62-1570-3 (1/26)