



A Carelon Company

APRETUDE (CABOTEGRAVIR) INJECTION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Apretude (cabotegravir)	<input type="checkbox"/> 600mg IM every month x 2 doses, then every 2 months thereafter <input type="checkbox"/> 600mg IM every 2 months (maintenance dosing)	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab Orders: HIV-1 RNA and antibody prior to each dose; LFTs at baseline, with 3rd dose, and Q6 months
 Other lab orders: _____

Required labs to be drawn by Infusion Center Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.	<input type="checkbox"/> Dispense as written
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PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:



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COMPREHENSIVE SUPPORT FOR APRETUDE (CABOTEGRAVIR) THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes (H&P) to support primary diagnosis - Including tried/failed medications
 - Has the patient tried and failed an oral PrEP? Yes No
 - Is the patient not a candidate for oral PrEP? Yes No
If no, list reason: _____
 - Provider attestation that patient demonstrates treatment readiness (i.e., ability to adhere to injection appointments, required labs, etc.)
 - Is the patient taking an oral lead-in? Yes No If yes, initiate Apretude 1-month following the start of oral lead-in on the last day of the oral lead-in dose
- Labs attached (**HIV-1 RNA and antibody required, LFTs if available**)
- Patient enrolled in ViiVConnect (1-844-588-3288)
- Other medical necessity: _____