PRESCRIPTION ORDER FORM

APRETUDE

(cabotegravir)

Suite Life
Infusing health and wellness into your life
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

• Negative HIV Test Date: _____

PRIMARY DIAGNOSIS

☐ Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
☐ Z11.4 Encounter for screening for human immunodeficiency virus (HIV)
☐ Z20.5 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
☐ Z20.6 Contact with and (suspected) exposure to HIV
☐ Z72.51 High-risk heterosexual behavior
☐ Z72.52 High-risk homosexual behavior
☐ Z72.53 High-risk bisexual behavior
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐ Solu-Medrol 40mg IVP ☐Solu-Cortef 125mg IVP ☐ Tyelnol 650mg PO ☐ Other: _____

PRIMARY MEDICATION ORDER

☐ Apretude 600mg IM monthly x 2 months, followed by Apretude 600mg IM every 2 months thereafter
☐ Other: _____

** ☐ Check here if utilizing oral lead-in (referring provider to prescribe and manage). Start date of oral lead-in:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless other wise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol
(See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date