McLeod Health

Cabotegravir (Apretude) Treatment Plan

Patient Name: _____ DOB: _____

Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one ICD-10 code):

☐ Z29.81 HIV Pre-Exposure Prophylaxis ☐ Z72.5___ High risk sexual behavior

☐ Other/Secondary ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Cabotegravir (Apretude) (J0739) 600 mg/3 mL administered subcutaneously via ventrogluteal site
- Order Frequency:
  - ☐ Induction: Once monthly for 2 months
  - ☐ Maintenance: Once every 2 months starting 2 months after completion of induction dosing
- Order Duration: 1 year unless otherwise specified (Other: _____)

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Screen patient for acute or primary HIV-1 via FDA approved test prior to starting therapy and prior to each subsequent injection. Report test results to infusion site prior to each injection.

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received cabotegravir at another facility, please provide last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798.
For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.