FUSIONDRIP
HYDRATION & WELLNESS

Apretude (cabotegravir) Injection Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ lb/kg
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ Z20.6 – Contact with and (suspected) exposure to HIV
☐ B20 – HIV disease resulting in infectious and parasitic diseases
☐ Other: _____ **ICD-10 Code:** _____

Injection Order

- ☐ 600 mg IM once monthly × 2 doses (Initiation Phase)
- ☐ 600 mg IM every 2 months (Maintenance Phase)
- ☐ Oral lead-in with Vocabria (cabotegravir): ☐ Yes ☐ No
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line

☒ Flush per standard injection protocol

Adverse Reaction & Anaphylaxis Orders

☒ Fusiondrip Hydration & Wellness Protocol (fusiondriphydration.com)
☐ Other – please fax preferred reaction orders to 614-413-3877

Premedication (Optional)

☐ Acetaminophen: ☐ 500 mg ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone: ☐ 40 mg ☐ 125 mg ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ HIV-1 RNA and antibody
☐ LFTs (baseline, 3rd dose, then every 6 months)
☐ Other: _____
Frequency: ☐ Prior to each dose ☐ Baseline only ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____