St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Cabotegravir (Apretude) For Preexposure Prophylaxis (PrEP)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Individuals must be tested for HIV-1 infection prior to initiating cabotegravir, and with each subsequent injection of cabotegravir, using a test approved or cleared by the FDA for the diagnosis of acute or primary HIV-1 infection. Do not initiate cabotegravir for HIV-1 pre-exposure prophylaxis (PrEP) unless negative infection status is confirmed. Individuals who become infected with HIV-1 while receiving cabotegravir for PrEP must transition to a complete HIV-1 treatment regimen.
3. A 4 week oral lead-in course can be considered to assess tolerability prior to initial injection, but is not required.
4. Contraindications: Hypersensitivity to cabotegravir; concomitant use with uridine diphosphate glucuronosyltransferase (UGT)1A1 enzyme inducers (anticonvulsants [e.g., carbamazepine, oxcarbazepine, phenobarbital, phenytoin], antimycobacterials [e.g., rifampin, rifapentine]; unknown or positive HIV-1 status (when used for HIV-1 preexposure prophylaxis).
5. Hepatoxicity has been reported in patients with or without known preexisting hepatic disease or other risk factors. Patients with underlying liver disease or marked elevations in transaminases prior to treatment may be at increased risk for worsening or development of transaminase elevations. Monitor liver chemistries and discontinue treatment if hepatotoxicity is suspected.
6. Depressive disorders, including altered or depressed mood, depression, mood swings, and suicidal ideation or attempt, have been reported. Evaluate patients with depressive symptoms to assess relation to cabotegravir use and risk/benefit of continued therapy. Discontinue treatment immediately if signs or symptoms of hypersensitivity reactions develop.
7. Carefully select individuals who agree to the required injection dosing and testing schedule and counsel individuals about the importance of adherence to scheduled dosing visits to help reduce the risk of acquiring HIV-1 infection and development of resistance.

NURSING ORDERS:

1. TREATMENT PARAMETER - HIV testing must be negative before initiation and each subsequent injection.

2. Monitor and record vital signs, tolerance, and presence of infusion-related reactions.
3. Cabotegravir (APRETUDE) second and continuation injections may be administered up to 7 days before or after the date the individual is scheduled to receive the injection.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

MEDICATIONS:

Initiation injections:

☐ Cabotegravir (APRETUDE) injection, 600 mg, intramuscular, once monthly for 2 doses; if using oral lead-in, first IM initiation injection should be administered on the last day of oral lead-in, or within 3 days after.

Continuation injections:

☐ Cabotegravir (APRETUDE) injection, 600 mg, intramuscular, once every 2 months, starting 2 months after the last injection.

Note: Second and continuation injections may be administered up to 7 days before or after the date the individual is scheduled to receive the injection.

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed