UNIVERSITY OF MIAMI

Apretude® (Cabotegravir) Injectable Initiation Patient Agreement Form
University of Miami PrEP Clinic

Last Name_____ First Name _____ DOB____/____/_____
MM DD YYYY

MRN_____ Redcap_____

I understand that to be eligible to receive the Apretude® injection (initial each statement after reviewing):

_____ The initiation of Apretude® injection is dependent upon my insurance benefits and requirements if I am currently insured

_____ I must come on time for all my scheduled appointments for the injectable medication.

_____ After receiving the first injection, I will receive a second injection after 30 days. Every subsequent injection will occur every 2 months

_____ The window period is 14 days for my second and maintenance injections (7 days before or 7 days after the target date)

_____ If I miss scheduled injections, I will have to go back to the oral treatment regimen

_____ If I miss scheduled injections there is a possibility I will be prescribed oral treatment indefinitely

_____ If my insurance status changes or my insurance updates their formulary and/or eligibility criteria, I may be prescribed an alternative treatment option

___ I will notify my health care provider if I am prescribed any other medication by other health care providers

If I break any of the terms above or if my health care provider decides that this medicine is hurting me more than helping me, this medicine may be stopped by my health care provider in a safe way.

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I have talked about this agreement with my doctor and I understand the above terms

_____ _____

Patient's signature Date (MM/DD/YYYY)

_____ _____

Provider Signature Date (MM/DD/YYYY)

This document has been discussed with and signed by the physician and patient. (A signed copy will be uploaded on UChart and a copy given to the patient)