Cabenuva®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Human immunodeficiency virus (HIV) disease, ICD10 B20

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS, and DURATION
Cabenuva® (Cabotegravir/Rilpivirine)	☐ **MONTHLY Dosing Schedule:** ☐ **Initiation Injections** • Inject Cabenuva (Cabotegravir 600mg + Rilpivirine 900mg) IM x 1 dose ☐ **Continuation Injections (starts 1 month after initiation injections)** • Inject Cabenuva (Cabotegravir 400mg + Rilpivirine 600mg) IM once monthly (± 7 days) x 1 year ☐ **EVERY 2-MONTHS Dosing Schedule:** ☐ **Initiation Injections** • Inject Cabenuva (Cabotegravir 600mg + Rilpivirine 900mg) IM once monthly (± 7 days) x 2 doses ☐ **Continuation Injections (starts 2 months after 2nd dose of initiation injections)** • Inject Cabenuva (Cabotegravir 600mg + Rilpivirine 900mg) IM once every 2 months (± 7 days) x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ HIV Viral load q _____ ☐ CD4 q _____ ☐ LFTs q _____

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient is virologically suppressed (HIV-1 RNA <50 copies/mL).

☐ The patient is currently on a stable antiretroviral regimen.

☐ If performed, HIV-1 Genotype testing shows that patient's HIV-1 is susceptible to cabotegravir and rilpivirine.

☐ Provider attests that patient understands the risks of missed doses of Cabenuva and can adhere to the required injection appointments.

LAB AND TEST RESULTS (required)

☐ Recent viral load

☐ Recent CD4+ count

☐ If performed, HIV-1 Genotype

☐ Other: _____

PRIOR FAILED ANTIRETROVIRAL THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____