Cabenuva

(cabotegravir/rilpivirine)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ B20 Human immunodeficiency virus (HIV) disease

☐ Z21 Asymptomatic HIV infection status

☐ Other: _____

PRESCRIPTION

☐ MONTHLY DOSING: Cabenuva (600mg cabotegravir/900mg rilpivirine) IM x 1 dose, followed by Cabenuva 400mg/600mg IM monthly thereafter *(First dose to be given on the last day of current antiretroviral therapy or oral lead-in)*

☐ EVERY 2-MONTH DOSING: Cabenuva (600mg cabotegravir/900mg rilpivirine) IM monthly x 2 doses, followed by Cabenuva 600mg/900mg IM every 2 months thereafter *(First dose to be given on the last day of current antiretroviral therapy or oral lead-in)*

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended standard pre-meds for Cabenuva.

☐ Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.