Cabenuva (cabotegravir + rilpivirine)

www.aleracare.com
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Provider Order Form rev. 5/20/2022

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

MEDICATION ORDER

Cabenuva (cabotegravir + rilpivirine)

Monthly Dosing schedule as follows:

Initiation injections

600-mg/900-mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy

Continuation injections

400-mg/600-mg IM (gluteal) monthly (begin 30 days after initiation injections)

Every 2 Months Dosing schedule as follows

Initiation injections

600-mg/900-mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy and then again 30 days later

Continuation injections

600-mg/900-mg IM (gluteal) every other month (begin 60 days after the last initiation injections)

Regimen Changes

Switch from Monthly to Every 2 Months injections

600-mg/900-mg IM (gluteal) given 30 days after the last injection of 400-mg/600-mg and then every 2 months thereafter

Switch from Every 2 months to Monthly injections

400-mg/600-mg IM (gluteal) given 2 months after the last injectionof 600-mg/900-mg then monthly thereafter

Oral Lead-In Therapy?

Yes → Date of last dose of Oral Lead-In:__________

No → Date of desired first Cabenuva injection:__________

LAB RESULTS (Viral load required before initiating therapy)

Viral Load __________ Date: __________

ICD-10 CODE

B20 Human immunodeficiency virus (HIV) disease

Z21 Asymptomatic human immunodeficiency virus (HJIV) infection status

Other:______________________________

Order Expiration Date (mm/dd/yy): ________________

(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order