aleracare
advanced infusion centers™

FAX 833.329.4738

Cabenuva (cabotegravir + rilpivirine)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

ICD-10 Code

◯ B20 Human immunodeficiency virus (HIV) disease ◯ Z21 Asymptomatic human immunodeficiency virus (HIV) infection status

◯ Other: _____

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

Medication Order

Cabenuva (cabotegravir + rilpivirine)

◯ **Monthly Dosing schedule as follows:**

Initiation injections

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

Continuation injections

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

◯ **Every 2 Months Dosing schedule as follows:**

Initiation injections

◯ 600mg/900mg 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

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

◯ Regimen Changes

◯ Switch from Monthly to Every 2 Months injections

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

◯ Switch from Every 2 Months to Monthly injections

◯ 400mg/600mg IM (gluteal) given 2 months after the last injection of 600mg/900mg 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 _____

Documentation Required (Note: Send all labs, must include specific labs listed here)

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

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯