

CABENUVA (CABOTEGRAVIR EXTENDED-RELEASE INJECTABLE SUSPENSION; RILPIVIRINE EXTENDED-RELEASE INJECTABLE SUSPENSION) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

DIAGNOSIS (Provider must specify)

HIV-1 infection in adults and adolescents 12 years of age and older and weighing at least 35 kg to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA <50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine.

Human immunodeficiency virus (HIV) disease, ICD 10: B20. _____
 Asymptomatic HIV infection status, ICD 10: z21. _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
| | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 | |

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MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Cabenuva	<input type="checkbox"/> Monthly dosing: Initiate injections of CABENUVA (600 mg of abotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in and continue with injections of CABENUVA (400 mg of cabotegravir and 600 mg of rilpivirine) every month thereafter.	Gluteal IM injection	<input type="checkbox"/> Every month <input type="checkbox"/> Every 2 months
	<input type="checkbox"/> Bimonthly dosing: Initiate injections of CABENUVA (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in for 2 consecutive months and continue with injections of CABENUVA every 2 months thereafter.		

New Start Therapy
 Continuation of Therapy
 Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

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