MRN:_____

Cabenuva (Cabotegravir/Rilpivirine) Plan of Treatment

NOTE: Patient ***may be ineligible*** to receive Cabenuva if patient if has hypersensitivity to the drug.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: ☐ **Z21** Asymptomatic HIV Infection Status

☐ **B20** Human immunodeficiency virus (HIV) disease

☐ **Initiation Injections: One-time dosing**

Cabenuva (Cabotegravir 600 mg/3 ml and Rilpivirine 900 mg/ 3 ml kit)

Administer Cabotegravir 600 mg and Rilpivirine 900 mg at separate **gluteal** injection sites (on opposite sides or 2 cm apart) intramuscularly X 1

☐ **Continuation Injections: begin 1 month after initiation injections**

Cabenuva (Cabotegravir 400 mg/2 ml and Rilpivirine 600 mg/2 ml kit)

Administer Cabotegravir 400 mg and Rilpivirine 600 mg at separate **gluteal** injection sites (on opposite sides or 2 cm apart) intramuscularly monthly

Monitor patient for 10 minutes after injections administered

4. Lab orders: _____

5. End Date of oral lead-in drug: _____

6. Date of previous injection: _____

7. Physician preferred method of contact: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

Physician's Signature:_____/_____**Date**: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's name with Credentials: _____ NPI: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

Revised 10/04/2021

MRN:_____

DOB:_____

Guidelines for Prescribing Cabenuva

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

- ☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
- ☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)
- ☐ Include documentation regarding tried and failed therapies.
- ☐ Include up to date medication list
- ☐ Affirmation of human immunodeficiency virus (HIV) diagnosis
- ☐ Confirmation of virologic suppression

Other as requested: _____

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.