

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

Cabenuva (cabotegravir/rilpivirine) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: <input type="checkbox"/> See list <input type="checkbox"/> NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/>	Z21 - Asymptomatic HIV Infection Status
<input type="checkbox"/>	B20 - Human immunodeficiency virus (HIV) disease
<input type="checkbox"/>	_____ - Other:

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	END DATE OF ORAL ANTIVIRAL:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		IF ORDER CHANGE:
5	Affirmation HIV diagnosis		Continue current order until insurance approved
6	Confirmation of virologic suppression		

MEDICATION ORDERS:

New Start Patients (to receive first injections on last day of oral antivirals)

<input type="checkbox"/>	Once monthly dosing schedule <u>Initiation injection:</u> Cabenuva 600mg/900mg intramuscularly x 1 dose <u>Maintenance injection:</u> Cabenuva 400mg/600mg intramuscularly every month	<input type="checkbox"/>	Every 2 month dosing schedule <u>Initiation injections:</u> Cabenuva 600mg/900 mg intramuscularly x 2 consecutive doses one month apart <u>Maintenance injections:</u> Cabenuva 600mg/900 mg intramuscularly every 2 months
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Changing Dosing Schedule

<input type="checkbox"/>	Monthly to every-2-months dosing <u>Transition dose:</u> Administer Cabenuva 600mg/900mg intramuscularly one month after the last monthly injection <u>Maintenance dosing:</u> Administer Cabenuva 600mg/900mg intramuscularly once every 2 months thereafter	<input type="checkbox"/>	Every-2-months to once monthly dosing <u>Transition dose:</u> Administer Cabenuva 400mg/600mg intramuscularly two months after the last every-2-month injection <u>Maintenance dosing:</u> Administer Cabenuva 400mg/600mg intramuscularly once monthly thereafter
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**Administer intramuscularly at separate gluteal injection sites (at least 2 cm apart)
Follow administration with a 10 minute post observation**

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

Dispense as written/Brand medically necessary	Substitution permitted



Checklist for referrals to AccuRX Infusion:

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**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com