Referral Status:	MRN:
☐ New referral ☐ Order change ☐ 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:	☐ See list	☐ NKDA

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

☐	Z21 - Asymptomatic HIV Infection Status
☐	B20 - Human immunodeficiency virus (HIV) disease
☐	_____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS AMINISTRATION: 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)

Once monthly dosing schedule

Initiation injection: Cabenuva 600mg/900mg intramuscularly x 1 dose

Maintenance injection: Cabenuva 400mg/600mg intramuscularly every month

Every 2 month dosing schedule

Initiation injections: Cabenuva 600mg/900 mg intramuscularly x 2 consecutive doses one month apart

Maintenance injections: Cabenuva 600mg/900 mg intramuscularly every 2 months

Changing Dosing Schedule

Monthly to every-2-months dosing

Transition dose: Administer Cabenuva 600mg/900mg intramuscularly one month after the last monthly injection

Maintenance dosing: Administer Cabenuva 600mg/900mg intramuscularly once every 2 months therafter

Every-2-months to once monthly dosing

Transition dose: Administer Cabenuva 400mg/600mg intramuscularly two months after the last every-2-month injection

Maintenance dosing: Administer Cabenuva 400mg/600mg intramuscularly once monthly therafter

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 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	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023