

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)

Z21 - Asymptomatic HIV Infection Status
B20 - Human immunodeficiency virus (HIV) disease
_____ - 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	Upon Approval	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	Every 2 month dosing schedule
<u>Initiation injection:</u> Cabenuva 600mg/900mg intramuscularly x 1 dose <u>Maintenance injection:</u> Cabenuva 400mg/600mg intramuscularly every month	<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

Maintenance Dosing

Once monthly dosing schedule	Every 2 month dosing schedule
<u>Maintenance injection:</u> Cabenuva 400mg/600mg intramuscularly every month	<u>Maintenance injections:</u> Cabenuva 600mg/900 mg intramuscularly every 2 months

Changing Dosing Schedule

Monthly to every-2-months dosing	Every-2-months to once monthly 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	<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

Administer intramuscularly at separate gluteal injection sites (at least 2 cm apart)

Follow administration with a 10 minute post observation

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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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	



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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com