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|---------------------------------------|---------------------------------------|--|--|
| 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)

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| 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>Initiation injections:</u> Cabenuva 600mg/900 mg intramuscularly x 2 consecutive doses one month apart |
| <u>Maintenance injection:</u> Cabenuva 400mg/600mg intramuscularly every month | <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>Transition dose:</u> Administer Cabenuva 400mg/600mg intramuscularly two months after the last every-2-month injection |
| <u>Maintenance dosing:</u> Administer Cabenuva 600mg/900mg intramuscularly once every 2 months thereafter | <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

Refills x 12 months unless noted otherwise here:

NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

| | |
|--|---|
| <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated. | 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 |