CABENUVA® Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Human immunodeficiency virus (HIV) disease
_____ Other: _____

Infusion Center Lab Orders (Check order for Infusion center to manage):

☐ LFTs at baseline and then every _____ weeks thereafter
☐ Other: _____

Please attach the following: 1. List of current Medications, Oral Lead-In Therapy of Cabotegravir & Rilpivirine initiated: _____ 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Recent Lab Results

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: CABENUVA® **(cabotegravir ER injectable suspension & rilpivirine ER injectable suspension)**

☐ ***New Start:***
Administer CABENUVA 600 mg/900 mg kit IM on the last day of oral lead in therapy

Goal IM Therapy Start Date (at least 28 days of oral lead in therapy recommended):_____

☐ ***Maintenance Regimen:*** _____# Refills (Recommend 10 Refills)
Administer CABENUVA 400 mg/600 mg kit IM monthly

Pre-Medication Orders: No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date