Cabenuva (cavotegravir / rilpivirine)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ B20 Human Immunodeficiency virus (HIV)
☐ Z21 Asymptomativ human immunodeficiency virus (HIV) infection status
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders / Results:

Required: Viral Load _____ *Date:* _____
☐ Other: _____

Cabenuva (cabotegravir + rilpivirine): Route: Intramuscular

Once Monthly Dose Schedule:

☐ **Initiation Dose:** 600mg/900mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy
☐ **Maintenance Dose:** 400mg/600mg IM (gluteal) monthly (begin 30 days after initiation injections) dose.

Every Two Month Dose Schedule:

☐ **Initiation Dose:** 600mg/900mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy and then again 30 days later
☐ **Maintenance Dose:** 600mg/900mg IM (gluteal) every other month (begin 60 days after the last initiation injections)

☐ **Regimen Changes:**

☐ Switch from Monthly to Every 2 Months injections: 600mg/900mg IM (gluteal) given 30 days after the last injection of 400mg/600mg and then every 2 months thereafter
☐ Switch from Every 2 Months to Monthly injections: 400mg/600mg IM (gluteal) given 2 months after the last injection of 600mg/900mg then monthly thereafter

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

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Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454