

Cabenuva (cabotegravir + rilpivirine)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

NKDA Allergies: _____ Weight lbs/kg: _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

MEDICATION ORDER

Cabenuva (cabotegravir + rilpivirine)

Monthly Dosing schedule as follows:

Initiation injections

600-mg/900-mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy

Continuation injections

400-mg/600-mg IM (gluteal) monthly (begin 30 days after initiation injections)

Every 2 Months Dosing schedule as follows

Initiation injections

600-mg/900-mg IM (gluteal) given on last day of oral lead in or last day of current antiretroviral therapy and then again 30 days later

Continuation injections

600-mg/900-mg IM (gluteal) every other month (begin 60 days after the last initiation injections)

Regimen Changes

Switch from Monthly to Every 2 Months injections

600-mg/900-mg IM (gluteal) given 30 days after the last injection of 400-mg/600-mg and then every 2 months thereafter

Switch from Every 2 months to Monthly injections

400-mg/600-mg IM (gluteal) given 2 months after the last injection of 600-mg/900-mg then monthly thereafter

Oral Lead-In Therapy?

Yes → Date of last dose of Oral Lead-In: _____

No → Date of desired first Cabenuva injection: _____

LAB RESULTS (Viral load required before initiating therapy)

Viral Load _____ Date: _____

ICD-10 CODE

B20 Human immunodeficiency virus (HIV) disease

Z21 Asymptomatic human immunodeficiency virus (HIV) infection status

Other: _____

Order Expiration Date (mm/dd/yy): _____

(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order