

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



ORDER FORM CABENUVA®

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION	
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: _____ Fax: _____	Email (for updates): _____

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

CABENUVA*:

(SELECT ONE OF THE FOLLOWING)

- _____ Recommended Monthly Dosing Schedule: Initiate injections of CABENUVA (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in and continue with injections of CABENUVA (400 mg of cabotegravir and 600 mg of rilpivirine) every month thereafter

- _____ Recommended Every-2-Month Dosing Schedule: Initiate injections of CABENUVA (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in **for 2 consecutive months** and continue with injections of CABENUVA every 2 months thereafter

Physician Signature _____ Date (Order is Valid for One Year) _____

REQUIRED DIAGNOSIS:
_____ HIV
Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:
_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinicals/ Progress Notes With Supporting DX
_____ Current Medication List
_____ Recent Labs
<input type="checkbox"/> Total Doses _____ <input type="checkbox"/> Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____