Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

ORDER FORM
CABENUVA®

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

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

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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

☐ Total Doses_____ ☐ Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____