

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____
DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG
ALLERGIES: _____ PREFERRED CLINIC: _____
REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

B20 Human immunodeficiency virus (HIV) disease
 Z21 Asymptomatic HIV infection status
 ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

Insurance Information List of Medications Tried & Failed Therapies Most Recent History & Physical Recent Lab Results

MEDICATION ORDER

NEW START PATIENTS
Initial dosing to begin on last day of oral antiviral lead-in therapy (prescribed & managed by referring provider)
Oral antiviral lead-in start date: _____

Once Monthly Dosing
 INITIAL: Cabenuva® (cabotegravir/rilpivirine) 600 mg/900 mg IM injection
 MAINTENANCE: Cabenuva® (cabotegravir/rilpivirine) 400 mg/600 mg IM injection every month
*Maintenance dosing scheduled one month following initial dose

Every 2 Month Dosing
 INITIAL: Cabenuva® (cabotegravir/rilpivirine) 600 mg/900 mg IM injection monthly for 2 doses
 MAINTENANCE: Cabenuva® (cabotegravir/rilpivirine) 600 mg/900 mg IM injection every 2 months
*Maintenance dosing scheduled 2 months following second initiation dose

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____
Patient to be observed for 15 minutes following the each injection. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____
EMAIL: _____ PHONE: _____ FAX: _____
ADDRESS (INCLUDE CITY, STATE, ZIP): _____
SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN