CABENUVA
(cabotegravir / rilpivirine)

FLOURISH™
HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

PRIMARY DIAGNOSIS

☐ B20 Human immunodeficiency virus (HIV) disease ☐ Other:_____
☐ Z21 Asymptomatic HIV infection status

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Cabenuva
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

Oral lead-in to be prescribed and managed by referring provider. Start Date: _____

☐ MONTHLY DOSING: Cabenuva (600mg cabotegravir / 900mg rilpivirine) IM x 1 dose, followed by Cabenuva 400mg / 600mg IM monthly thereafter (First dose to be given on the last day of current antiretroviral therapy or oral lead-in.)

☐ EVERY 2-MONTH DOSING: Cabenuva (600mg cabotegravir / 900mg rilpivirine) IM monthly x 2 doses, followed by Cabenuva 600mg / 900mg IM every 2 months thereafter. (First dose to be given on the last day of current antiretroviral therapy or oral lead-in.)

☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date