CABENUVA INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION	Fax completed form, insurance information, and clinical documentation to 331-314-8989				
Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	□ inches □ cm	Weight:	□ lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION			
Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)		
Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Cabenuva (cabotegravir/rilpivirine)	**Monthly** adult dosing: □ Cabotegravir 600mg/rilpivirine 900mg IM x1 dose, then cabotegravir 400mg/rilpivirine 600mg IM every month thereafter □ Cabotegravir 400mg/rilpivirine 600mg IM every month **Every 2-month** adult dosing: □ Cabotegravir 600mg/rilpivirine 900mg IM monthly x2 doses, then cabotegravir 600mg/rilpivirine 900mg IM every 2 months thereafter □ Cabotegravir 600mg/rilpivirine 900mg IM every 2 months	□ x1 year □ _____

Other orders: _____

Lab Orders: _____ Lab Frequency: _____

Required labs to be drawn by □ Infusion Center □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR CABENUVA THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to other therapy

- ☐ Has the patient been stable on an antiretroviral regimen? □ Yes □ No

  If yes, which drug drug(s)? _____

- ☐ Does the patient have difficulty maintaining compliance with a daily antiretroviral regimen for HIV-1 OR have gastrointestinal issues that may limit absorption or tolerance of oral medications? □ Yes □ No

- □ Will the patient receive oral lead-in with cabotegravir (Vocabria) and rilpivirine (Edurant) for at least 28 days prior to the initiation of Cabenuva to assess the tolerability of cabotegravir and rilpivirine? □ Yes □ No

☐ Include labs and/or test results to support diagnosis

- ☐ Does the patient have HIV-1 RNA less than 50 copies per mL? □ Yes □ No

  HIV RNA (attach results)

☐ Other medical necessity: _____