Cabotegravir/Rilpivirine (Cabenuva)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

HIV infection (to replace current stable antiretroviral regimen):

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Induction: Administer Cabotegravir 600mg /Rilpivirine 900mg IM as separate gluteal injections (on opposite sides at least 2cm apart) on week 0.

☑ Maintenance: administer Cabotegravir _____ mg /Rilpivirine _____ mg IM as separate gluteal injections (on opposite sides at least 2cm apart) one month after initial injection followed by every _____ months.

☑ Monitor patient for 10 minutes after every injection. Vital signs prior to discharge.

ADDITIONAL ORDERS

NURSING

☑ Hold infusion and notify provider if patient has not adhered to the monthly or every other monthly regimen.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

PRE-MEDICATION ORDERS

☐ Other: _____

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Confirmation of HIV-1 diagnosis/Greater than 18 years of age, Virologic suppression for at least 6months (HIV-1 RNA<50 copies/ml), Documentation of adherence to oral therapy, No history or TF/resistance to medication, Complete medication profile (contraindication of use with cabamazepime, oxycarbazepine, phenobarbital, phenytoin, Rifabutin, Rifampin, Rifapentine, steroids, St. John's Wort)

Required Labs: LFT, Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.