Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Cabenuva (cabotegravir and rilpivirine)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS

☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)

☐ Richmond ☐ Prince George

DIAGNOSIS AND ICD-10 CODE

☐ Human Immunodeficiency Virus (HIV) disease B20
☐ Other: _____ ICD10 _____

REQUIRED DOCUMENTATION (must include)

☐ This signed order form by the provider
☐ Patient Demographics AND Insurance Information
☐ Documentation that patient is virologically suppressed (viral load <50 copies/mL)
☐ Testing shows patient's HIV-1 is susceptible to cabotegravir and rilpivirine
☐ Clinical/Progress Notes
☐ Labs and Tests Supporting Primary Dx
☐ Documentation that patient is stable on current antiretroviral regimen or supporting documentation as to why they are not
☐ Documentation patient has had or will have oral lead-in therapy with cabotegravir and rilpivirine for at least 28 days
☐ Patient currently receiving same therapy at _____ Last dose: _____

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

MEDICATION ORDERS*

Once Monthly Dosing	☐ Initial: Cabotegravir 600mg IM and Rilpivirine 900mg IM x 1 dose ☐ Maintenance: Cabotegravir 400mg IM and Rilpivirine 600mg IM monthly
Every 2-Month Dosing	☐ Initial: Cabotegravir 600mg IM and Rilpivirine 900mg IM monthly x 2 doses ☐ Maintenance: Cabotegravir 600mg IM and Rilpivirine 900mg IM Q 2-months

Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____

* If the patient misses the scheduled target injection window by ≥7 days, the ordering provider will be promptly notified by Infusion Solutions, LLC. It will be the ordering provider's responsibility to obtain oral replacement dosages until Cabenuva can be resumed.

OPTIONAL PREMEDICATION and LAB ORDERS

☐ Acetaminophen 650mg PO prior to Cabenuva administration
☐ Diphenhydramine 25mg PO prior to Cabenuva administration
☐ Methylprednisolone 40mg slow IVP prior to Cabenuva administration
☐ Other premed or lab order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION

Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.