



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Human immunodeficiency virus (HIV) disease
 _____ Other: _____

Infusion Center Lab Orders (Check order for Infusion center to manage):

- LFTs at baseline and then every _____ weeks thereafter
- Other: _____

Please attach the following: 1. List of current Medications, **Oral Lead-In Therapy of Cabotegravir & Rilpivirine initiated:** _____ 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Recent Lab Results

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: CABENUVA® (cabotegravir ER injectable suspension & rilpivirine ER injectable suspension)

New Start:

Administer CABENUVA 600 mg/900 mg kit IM on the last day of oral lead in therapy

Goal IM Therapy Start Date (at least 28 days of oral lead in therapy recommended): _____

Maintenance Regimen:

_____ # Refills (Recommend 10 Refills)

Administer CABENUVA 400 mg/600 mg kit IM monthly

Pre-Medication Orders: No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date