INTRAMED Plus
infusion services

# CABENUVA®

## INFUSION & MEDICAL CENTER

**1.** _____ _____ _____
**Patient Name** **DOB** **Patient Phone/Cell #**

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please complete/select appropriate diagnosis):**

Primary Diagnosis: _____ Human immunodeficiency virus (HIV) disease ICD-10 Code: B20._____
_____ Other:_____ ICD-10 Code: _____
Allergies:_____(or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results
- Medication List
  - Oral Lead-In Therapy of Cabotegravir & Rilpivirine initiated: _____

**Patient**
**Weight:** _____ lbs.
**Height:** _____ in.

Infusion Center Lab Orders (Check order for Infusion center to manage):
❑ LFTs at baseline and then every _____ weeks thereafter
❑ Other: _____

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**CABENUVA®** J Code: _____

(cabotegravir ER injectable suspension & rilpivirine ER injectable suspension)

**4. Drug Order:**

❑ **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

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

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

**5. Physician Signature:** _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

| FAX ALL INFORMATION | INFUSION CENTER LOCATIONS |
|---|---|
| CENTRAL FAX **803.999.1754** | **COLUMBIA CHARLESTON GREENVILLE**<br>**CENTRAL INTAKE PHONE 800.767.6337** |