

**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: \_\_\_\_\_

<b>Patient</b> <b>Weight:</b> _____ lbs. <b>Height:</b> _____ in.
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Infusion Center Lab Orders (Check order for Infusion center to manage):

- LFTs at baseline and then every \_\_\_\_\_ weeks thereafter  
 Other: \_\_\_\_\_

**CABENUVA®**

J Code: J0741

(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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 800.767.6337</b>
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