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

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: _____

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 once monthly. Provide _____ dose(s).

❑ **Maintenance Regimen:** _____# Refills (Recommend 10 Refills)

❑ Administer CABENUVA 400 mg/600 mg kit IM monthly
❑ Two months after the final initiation injection, administer CABENUVA 600 mg/900 mg IM every two months

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 CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**