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** **ALTERNATE FAX 803.999.1887**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1960**