Los Angeles, CA 2080 Century Park East Suite 710 Los Angeles, CA 90067

Provider _____





Phone _____ Fax _____

Office: 310-481-9944 Fax: 310-766-7001

ORDER FORM CABENUVA

IAI	TENT INFORMATION
Name:	DOB: SEX: M 🗆 F 🗆
Allergies:	Date of Referral:
PHYS	SICIAN INFORMATION
Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):
R	EFERRAL STATUS
□New Referral □Referral Renewal □Medication/0	Order Change Benefits Verification Only Discontinuation Ord
mg of rilpivirine) on the last day of current anti of CABENUVA (400 mg of cabotegravir and 60 Recommended Every-2-Month Dosing Schedul	e: Initiate injections of CABENUVA (600 mg of cabotegravir rent antiretroviral therapy or oral lead-in for 2 consecutive
	(Order is Valid for One Year)
REQUIRED DIAGNOSIS:	REQUIRED DOCUMENTATION CHECKLIST:
HIV	Patient Demographics
	Incurance Card/Information
	Insurance Card/Information
	Insurance Card/Information Clinicals/ Progress Notes With Supporting DX
	Clinicals/ Progress Notes With Supporting DX Current Medication List
	Clinicals/ Progress Notes With Supporting DX
	Clinicals/ Progress Notes With Supporting DX Current Medication List
Last Infusion/Injection Date:	Clinicals/ Progress Notes With Supporting DX Current Medication List Recent Labs
Last Infusion/Injection Date: NOTES/ADDITIONAL COMMENTS:	Clinicals/ Progress Notes With Supporting DX Current Medication List Recent Labs
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