Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

ORDER FORM CABENUVA®

Date: ____________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:		Practice Name:
Address:		Office Contact*:
Phone:	Fax:	Email (for updates):

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

CABENUVA*:

*(SELECT **ONE** OF THE FOLLOWING)*

_______ Recommended Monthly Dosing Schedule: Initiate injections of CABENUVA (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in and continue with injections of CABENUVA (400 mg of cabotegravir and 600 mg of rilpivirine) every month thereafter

_______ Recommended Every-2-Month Dosing Schedule: Initiate injections of CABENUVA (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of current antiretroviral therapy or oral lead-in **for 2 consecutive months** and continue with injections of CABENUVA every 2 months thereafter

Physician Signature ______________________________ **Date (Order is Valid for One Year)**__________________

REQUIRED DIAGNOSIS:

______ HIV

Last Infusion/Injection Date: ________________________

REQUIRED DOCUMENTATION CHECKLIST:

______ Patient Demographics

______ Insurance Card/Information

______ Clinicals/ Progress Notes With Supporting DX

______ Current Medication List

______ Recent Labs

☐ Total Doses_______ ☐ Refills ________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ____ Date ______________

Provider ____________________________ Phone ____________ Fax ______________