

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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 _____