Phone: (833) 394-0600 Fax: (616) 818-4484

Cabenuva Injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: _________________________ **Patient Weight:** ________lbs / kg **Height:**____________

ICD-10 : ______________________, _________________________, ________________________

What medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use	Reason for discontinuation

End date of oral treatment: ________________________ Date of last injection: __________________________

Cabenuva (cabotegravir/rilpivirine) Intramuscular injection

Once a month dosing schedule:

☐Induction: Cabotegravir 600mg/Rilpivirine 900mg x 1

☐Maintenance: Cabotegravir 400mg/Rilpivirine 600mg every month

Every two month dosing schedule:

☐Induction: Cabotegravir 600mg/Rilpivirine 900mg x 2 doses given 1month apart

☐Maintenance: Cabotegravir 600mg/Rilpivirine 900mg every 2 months

Switching dosing schedules:

☐ Monthly to every 2 month dosing:
Cabotegravir 600mg/Rilpivirine 900mg after the last injection then every 2 months thereafter

☐ Every 2 month to monthly dosing:
Cabotegravir 400mg/Rilpivirine 600mg after the last injection then every month thereafter

Printed Provider Name: ____

Provider Signature: ____

Office Phone Number: ____________________**Office Fax Number:** ______________________________

Contact Name: ______________________**Contact Phone Number:** ______________________________

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _______________