REVITALIZE
INFUSION CENTER

Cabenuva®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Human immunodeficiency virus (HIV) ICD-10 Code: B20

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Relevant labs and tests
- Required Information:
  - HIV RNA Results
  - Oral lead- in therapy of cabotegravir & rilpivirine initiated on:_____

Height: _____

Weight: _____

Cabenuva (cabotegravir & rilpivirine) Orders:

☐ **New Start:** Administer Cabenuva 600 mg/900 mg IM once monthly for _____ month(s)

☐ **Maintenance Dose:**

☐ Administer Cabenuva 400 mg/600 mg IM monthly for 12 months

☐ Administer Cabenuva 600 mg/900 mg IM every 2 months for 12 months

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders:

☐ LFTs at baseline then every _____ weeks

☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus