

CABENUVA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F

Address: _____ Phone: _____ Email: _____

Height (in): _____ Weight (lb): _____ Referral Status: New Updated Renewal

Infusion/ Injection Information

Primary ICD-10 Code: _____ Primary ICD-10 Description: _____

Other ICD-10 Codes: _____ Other ICD-10 Descriptions: _____

Cabenuva (Cabptegravir & Rilpivirine) Dosing Info:

- Initial Dosing, _____ mg IM
Day ____ and Day ____
- Maintenance Dosing, _____ mg IM
Every ____ Months for ____ Months
- Maintenance Dosing, _____ mg IM
Every ____ Months for ____ Months

Premedications:

- _____

Required Documentation:

- Full Patient Chart
- Insurance Cards (Front and Back)
- Clinical Notes Supporting Diagnosis
- List of Current Medications, Conditions, and Allergies

Ordering Provider Information

Practice Name: _____ Practice Phone: _____ Practice Fax: _____

Practice Address: _____ Referral Coordinator Name: _____

Referral Coordinator Email: _____ Referral Coordinator Phone: _____

Ordering Provider: _____ Provider NPI: _____ Specialty: _____

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name

Provider Signature

Date