Wells Infusion Centers

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)

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds* _____

■ **Diagnosis**

☐ B20 Human immunodeficiency virus (HIV) disease ☐ Z21 Asymptomatic HIV infection status

■ **Details Needed for Approval** *Please answer all questions and provide supporting documentation.*

- Does the patient have a confirmed diagnosis of HIV-1? _____
- Is the patient at least 18 years of age? _____
- Is the patient ART-experienced with demonstrated virologic suppression (HIV-1 RNA < 50 copies/ml) in past 12 months? _____
  If the answer to the above question is Yes, please send all lab results from past year demonstrating viral suppression.
- Does the patient have a history of treatment failure? _____
- Does the patient have known substitutions associated with resistance to cabotegravir or rilpivirine? _____
- Does the patient exhibit neurodiversity or behavioral health condition which impairs their ability to manage multiple meds? _____
- Does the patient have a gastrointestinal condition which limits absorption or tolerance of oral medications? _____
- Does the patient have cognitive impairment requiring assistance with activities of daily living? _____
- Will the patient be initiated on oral cabotegravir/rilpivirine therapy for at least 1 month prior to initiating Cabenuva? _____
- Will Cabenuva be co-administered with other ART medication, carbamazepine, dexamethasone (aside from single-dose treatment), oxcarbazepine, phenobarbital, phenytoin, ribafutin or rifampin? _____
- Are you a specialist in HIV or infectious disease? _____ If not, have you consulted a specialist, and who? _____
- Has your office already enrolled the patient in ViiVConnect? _____

■ **Medication Order** *Select only <u>one</u> dosage regimen. Any oral initial therapy should be sent separately to the patient's pharmacy.*

☐ New Monthly dosage: Cabenuva 600-900 syringes monthly for 2 months, then Cabenuva 400-600 every month, for 1 year.
☐ New Bi-Monthly dosage: Cabenuva 600-900 syringes monthly for 2 months, then Cabenuva 600-900 every other month, for 1 year.
☐ Maintenance Monthly dosage: Cabenuva 400-600 syringes every month for 1 year.
☐ Maintenance Bi-Monthly dosage: Cabenuva 600-900 syringes every other month for 1 year.

Nurse instructions: Medication shall not be removed from the refrigerator until the patient is ready to be injected – it may not be cycled in and our of cold storage. Each kit contains two syringes which must come to room temperature and then be administered to separate gluteal sites (or at least 2cm apart). Check vitals and monitor for signs and symptoms before and after completion. There is a 10 minute observation period following administration. Follow-up appointments should be scheduled for a target date of the month (ie. Every 15th of each or every other month) and not every 4 or 8 weeks.

■ **Rescue Management in Case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.