

Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____

Height _____ Weight _____

Infusion Location: (state and Site) _____

Cabenuva(Cabotegravir/Rilpivirine)

Diagnosis-provide ICD-10 code

_____ HIV infection (to replace current stable antiretroviral regimen)
_____ Other _____

Nursing Orders: Hold if patient has not adhered to the monthly or every other monthly regimen.

Documentation Needed for Approval

- Confirmation of HIV-1 diagnosis/Greater than 18 years of age
- Virologic suppression for at least 6months (HIV-1 RNA<50 copies/ml)/ Documentation of adherence to oral therapy
- No history or TF/resistance to medication
- Labs include LFT, Renal function.
- Complete medication profile (contraindication of use with cabamazepime, oxycarbazepine, phenobarbital, phenytoin, Rifabutin, Rifampin, Rifapentine, steroids, St. John's Wort)

Administration: (see dosing guide below)

<ul style="list-style-type: none">• Administer Cabotegravir _____ mg/Rilpivirine _____ mg IM as separate gluteal injections (on opposite sides at least 2cm apart) every _____ months.

- Medication needs at least 15mins outside of fridge to come to room temp.
- Shake each vial vigorously so suspension looks uniform.
- Post injection observation is 10mins
- Check vitals prior to discharge.
- **If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol to include administration of epinephrine 0.3 mg IM STAT.**

Dosing information:

Table 1. Recommended Dosing Schedule with Optional Oral Lead-in or Direct to Injection for **Monthly** Injection

Drug	Oral lead-In (at least 28 days)*	Intramuscular (Gluteal) Initiation Injections (One time dosing)	Intermuscular (Gluteal) Continuation Injections (Once Monthly Dose)
	Prior to starting injections	Initial injection on Month 1#	One month after initial injection and monthly
Cabotegravir	30mg PO Q day with meal	600mg	400mg
Rilpivirine	25mg PO Q day with meal	900mg	600mg

*The optional oral therapy should be continued until the day the first injection is administered.

#Given on the last day of current antiretroviral therapy or oral lead-in if used.

Recommended Dosing with oral lead in or direct injection for every **2 month** injections

Drug	Optional oral lead in*	Intramuscular (Gluteal) Injections#
------	------------------------	-------------------------------------

Provider name (print): _____ Date: _____

Provider signature: _____ Time: _____

Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____

Height _____ Weight _____

Infusion Location: (state and Site) _____

	Month (at least 28 days) Prior to start of injections	Initiate Injections@ at Month 1, Month 2 and then every 2 months onward (start at month 4)
Cabotegravir	30mg Q day with meal	600mg
Ripivirine	25mg Q day with meal	900mg

* The optional oral therapy should be continued until the day the first injection is administered.

#For the every-2-month injection dosing schedule in adults, Initiation Injections are injections administered at Month 1 and Month 2 and Continuation Injections are injections administered every 2 months onwards (starting Month 4).

@ Given on the last day of current antiretroviral therapy or oral lead-in if used.

Provider name (print): _____ Date: _____

Provider signature: _____ Time: _____