Cabotegravir/Rilpivirine (Cabenuva)

Provider Order Form rev. 03/19/2026

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS ***(Please provide ICD-10 code in space provided)***

HIV infection (to replace current stable antiretroviral regimen):

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Induction: Administer Cabotegravir 600mg /Rilpivirine 900mg IM as separate gluteal injections (on opposite sides at least 2cm apart) on week 0.

☑ Maintenance: administer Cabotegravir _____ mg /Rilpivirine _____ mg IM as separate gluteal injections (on opposite sides at least 2cm apart) one month after initial injection followed by every _____ months.

☑ Monitor patient for 10 minutes after every injection. Vital signs prior to discharge.

NURSING

☑ Hold infusion and notify provider if patient has not adhered to the monthly or every other monthly regimen.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

PRE-MEDICATION ORDERS

☐ Other: _____

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, 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, Complete medication profile (contraindication of use with cabamazepime, oxycarbazepine, phenobarbital, phenytoin, Rifabutin, Rifampin, Rifapentine, steroids, St. John's Wort)

Required Labs: LFT, Renal function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.