

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List

PRIMARY DIAGNOSIS

- ☐ B20 Human immunodeficiency virus (HIV) disease
☐ Z21 Asymptomatic HIV infection status
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- ☒ Per infusion clinic protocol: There are no recommended standard pre-meds for Cabenuva
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- ☐ MONTHLY DOSING: Cabenuva (600mg cabotegravir / 900mg rilpivirine) IM x 1 dose, followed by Cabenuva 400mg / 600mg IM monthly thereafter (First dose to be given on the last day of current antiretroviral therapy or oral lead-in.)
☐ EVERY 2-MONTH DOSING: Cabenuva (600mg cabotegravir / 900mg rilpivirine) IM monthly x 2 doses, followed by Cabenuva 600mg / 900mg IM every 2 months thereafter. (First dose to be given on the last day of current antiretroviral therapy or oral lead-in.)
☐ Other: _____
** ☐ Check here if utilizing oral lead-in (referring provider to prescribe and manage). Start date of oral lead-in: _____
First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy) ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date