RESTORE HEALTH
INFUSION AND WELLNESS

CABENUVA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, HIV Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐M ☐F ☐Other Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ B20 (HIV Disease) ☐ Z21 (Asymptomatic HIV Infection Status) ☐Other: _____

Allergies: _____ Weight: _____ ☐Kg ☐Lbs Height: _____ ☐ cm ☐ in

HBV: ☐Yes ☐No Current Antiretroviral Therapy: _____ Last treatment date: _____

TREATMENT INFORMATION

CABENUVA (cabotegravir/rilpivirine)

Route: Gluteal Intramuscular

Dose: ☐ 400mg/600mg kit
☐ 600mg/900mg kit

Frequency:

Monthly Dosing:

☐ Initiation: 600mg/900mg on final day of current antiretroviral therapy

☐ Maintenance: 400/600mg monthly

Every-2-Month Dosing:

☐ Initiation: 600mg/900mg on final day of current antiretroviral therapy

☐ Maintenance: 600/900mg every 2 months

Quantity: _____ **Refills:** _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐IV

☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____