Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

CABENUVA (CABOTEGRAVIR-RILPIVIRINE) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

If New to Therapy, will patient be started on oral lead-in of Vocabria (cabotegravir) and Edurant® (rilpivirine)?

☐ No ☐ Yes- recommend oral lead-in should **NOT** be started until any applicable Cabenuva payor authorization has been secured.

If Yes, has patient started oral lead-in of Vocabria (cabotegravir) and Endurant® (rilpivirine)?

☐ No – Upon securing applicable prior authorization, Option Care Health will follow-up with prescriber to coordinate oral lead-in.

☐ Yes – Start Date: _____

If Continuing Therapy, date of last injection (if known): _____ **Date of next injection:** _____

Cabenuva (Cabotegravir-Rilpivirine) Prescription

Once Monthly Dose Schedule

☐ Initiation Dose: Nurse to administer cabotegravir 600 mg and rilpivirine 900 mg via intramuscular injection x 1 dose on the last day of current antiretroviral therapy or oral lead-in (at least 28 days). Discontinue current antiretroviral therapy or oral lead-in after Cabenuva administration. Dispense Cabenuva 600 mg | 900 mg kit x 1 dose

☐ Maintenance Dose: Nurse to administer cabotegravir 400 mg and rilpivirine 600 mg via intramuscular injection monthly (+/– 7 days to allow for patient/nurse scheduling) beginning 1 month after completion of initiation doses. Dispense Cabenuva 400 mg | 600 mg kit x 1 dose with refills x 1 year

Every 2 Month Dose Schedule

☐ Initiation Doses: Nurse to administer cabotegravir 600 mg and rilpivirine 900 mg via intramuscular injection monthly x 2 months dose on the last day of current antiretroviral therapy or oral lead-in (at least 28 days) (+/– 7 days to allow for patient/nurse scheduling). Discontinue current antiretroviral therapy or oral lead-in after Cabenuva administration. Dispense Cabenuva 600 mg | 900 mg kit x 1 dose with refills x 1

☐ Maintenance Dose: Nurse to administer cabotegravir 600 mg and rilpivirine 900 mg via intramuscular injection every two months (+/– 7 days to allow for patient/nurse scheduling) beginning 2 months after completion of initiation doses. Dispense Cabenuva 600 mg | 900 mg kit x 1 dose with refills x 1 year

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders

☐ Other: _____

Lab Orders

☐ No labs ordered at this time

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

