



option care health®

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 Edurant® (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: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.