Cabenuva Referral Form

Please complete the following and send with clinical documentation to:
p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

REFERRAL PROCESS

1. PATIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile: _____
Email: _____
DOB: _____ Social Security #: _____
Gender: ☐ M ☐ F ☐ Nonbinary Height: _____ Weight: _____

2. PHYSICIAN INFORMATION

Physician's name: _____
License #: _____ NPI #: _____
DEA #: _____
Address: _____
City: _____ State: _____ Zip: _____
Office Contact: _____
Phone: _____ Fax: _____

Allergies*: _____ NKA*: ☐
Alternate contact name: _____ Alternate contact phone: _____
Consent to leave voice message at the patient and/or alternate contact phone ☐ Yes ☐ No*

3. DIAGNOSIS

☐ HIV (B20)
☐ Other Diagnosis _____
Has the patient started on oral lead-in therapy of Cabotegravir and Rilpivirine? ☐ No ☐ Yes
If yes, what was the date of the first dose? _____
Has the patient demonstrated hypersensitivity to Cabotegravir or Rilpivirine? ☐ No ☐ Yes
What is the current viral load? _____copies/mL

4. INSURANCE INFORMATION **Please submit copies of the front and back of primary and secondary insurance cards with this referral.**

5. MEDICATION ORDERS (Medication, Dosage, Duration, Pre-Medication)

Cabenuva® (Cabotegravir/Rilpivirine)-follow manufacturer dosing guidelines

☐ **Monthly**:
Initiation Dose: Inject intramuscularly (Gluteal) Cabotegravir 600 mg (3 mL) and Rilpivirine 900mg (3 mL)
Continuation Dose: Inject intramuscularly (Gluteal) once monthly Cabotegravir 400 mg (2 mL) and Rilpivirine 600 mg (2 mL)
Comments: _____

Or

☐ **Every 2 Months:**
Initiation Dose: For Months 1 and 2, inject intramuscularly (Gluteal) Cabotegravir 600 mg (3 mL) and Rilpivirine 900mg (3 mL)
Continuation Dose: Starting at Month 4, inject intramuscularly (Gluteal) once every 2 months Cabotegravir 600 mg (3 mL) and Rilpivirine 900mg (3 mL)
Comments: _____

6. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.
☐ **Other** _____

7. NURSE ORDERS

RN to assess, administer, and/or instruct patient/caregiver on medication, administration, vascular access device, disease process, signs or symptoms of adverse effects or complications of therapy. RN to establish, maintain and discontinue vascular access device. RN to draw labs as ordered via vascular access device or venipuncture.

8. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.