

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



CABENUVA ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Cabenuva	<input type="checkbox"/> Monthly Dosing: Administer Cabenuva (600mg/900mg) intramuscularly x one dose, followed by Cabenuva (400mg/600mg) intramuscularly every month. <input type="checkbox"/> Every 2 Month Dosing: Administer Cabenuva (600mg/900mg) intramuscularly monthly x two doses, followed by Cabenuva (600mg/900mg) intramuscularly every two months. <input checked="" type="checkbox"/> Administer as two IM injections at separate gluteal sites during same visit. <input checked="" type="checkbox"/> If initiating therapy, administer first dose on the last day of current antiretroviral therapy or oral lead-in, if used.	Refills for one year from date of signature unless indicated below. _____ Refills	<p><i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i></p> <input checked="" type="checkbox"/> HIV-1 RNA within the last six months confirming virologic suppression
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PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	IV <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written: _____ Prescriber Name Date	Substitution Allowed: _____ Prescriber Name Date
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