Hy-Vee health

CABENUVA
Injection Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ HIV (ICD-10 code: B20)

☐ Other: _____ **ICD-10 Code:** _____

Patient Weight: _____ lbs. **Allergies:** _____

Therapy Order

Cabenuva

Monthly adult dosing:

☐ Cabotegravir 600 mg/rilpivirine 900 mg IM x1 dose, then cabotegravir 400 mg/rilpivirine 600 mg IM every month thereafter

Every 2-months adult dosing:

☐ Cabotegravir 600 mg/rilpivirine 900 mg IM monthly x2 doses, then cabotegravir 600 mg/rilpivirine 900 mg IM every 2 months thereafter

Refill for: ☐ 6 months ☐ 12 months Other: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other Orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

COMPREHENSIVE SUPPORT FOR CABENUVA THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to other therapy

- ☐ Has the patient been stable on an antiretroviral regimen? ☐ Yes ☐ No

  If yes, which drug drug(s)? _____

- ☐ Does the patient have difficulty maintaining compliance with a daily antiretroviral regimen for HIV-1 OR have gastrointestinal issues that may limit absorption or tolerance of oral medications? ☐ Yes ☐ No

- ☐ Will the patient receive oral lead-in with cabotegravir (Vocabria) and rilpivirine (Edurant) for at least 28 days prior to the initiation of Cabenuva to assess the tolerability of cabotegravir and rilpivirine? ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

- ☐ Does the patient have HIV-1 RNA less than 50 copies per mL? ☐ Yes ☐ No

  HIV RNA (attach results)

☐ Other Medical Necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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