Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

CABENUVA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ **Diagnosis** *Some insurance carriers require <u>both</u> diagnosis codes below for prior authorization.*

☐ B20 Human immunodeficiency virus (HIV) disease ☐ Z21 Asymptomatic HIV infection status

■ **Details Needed for Authorization** *Please answer all questions and provide supporting documentation.*

- Does the patient have a confirmed diagnosis of HIV-1? _____
- Is the patient at least 18 years of age? _____
- Is the patient ART-experienced with virologic suppression for at least 6 months (HIV-1 RNA < 50 copies/mL)? _____
- Does the patient have a history of treatment failure? _____
- Does the patient have known substitutions associated with resistance to cabotegravir or rilpivirine? _____
- Does the patient exhibit neurodiversity or a behavioral health condition which impairs their ability to manage multiple medications? _____
- Does the patient have severe substance abuse disorder? _____
- Does the patient have a diagnosed swallowing disorder? _____
- Does the patient have cognitive impairment requiring assistance with activities of daily living? _____
- Will the patient be initiated on oral cabotegravir/rilpivirine therapy for at least 1 month prior to initiating Cabenuva? _____
- Will Cabenuva be co-administered with other ART medication, carbamazepine, dexamethasone (aside from a single-dose treatment), oxcarbazepine, phenobarbital, phenytoin, rifabutin, or rifampin? _____

■ **Cabenuva (cabotegravir/rilpivirine) Medication Order** **Patient's height in ft/in: _____ Patient's weight in lbs: _____**

Select only <u>one</u> dosage regimen. 28 days of oral medication lead-in to be handled by prescriber and patient's pharmacy separately.

☐ Monthly dosage: Cabenuva 600-900mg syringes initially, then Cabenuva 400-600mg syringes every 1 month for _____ months.

☐ Every-2-Month dosage: Cabenuva 600-900mg syringes monthly for the first 2 months, then Cabenuva 600-900mg syringes every other month for _____ months.

☐ Maintenance monthly dosage: Cabenuva 400-600mg syringes every 1 month for _____ months. Last dose date: _____.

☐ Maintenance 2-month dosage: Cabenuva 600-900mg every other month for _____ months. Last dose date: _____.

Medication shall not be removed from the refrigerator until the patient is ready to be injected – it may not be cycled in and out of cold storage. Each kit contains two syringes, which must be administered to separate gluteal sites (either opposite sides or 2 cm apart). Check vitals and monitor for signs and symptoms before administration and after completion. Follow-up appointments should be scheduled for a target date of the month (ie. every 15th of each month), and <u>not</u> every 4 weeks.

■ **Rescue Management in case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.