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: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Cabenuva

☐ Monthly Dosing:
Administer Cabenuva (600mg/900mg) intramuscularly x one dose, followed by Cabenuva (400mg/600mg) intramuscularly every month.

☐ Every 2 Month Dosing:
Administer Cabenuva (600mg/900mg) intramuscularly monthly x two doses, followed by Cabenuva (600mg/900mg) intramuscularly every two months.

✓ Administer as two IM injections at separate gluteal sites during same visit.

✓ If initiating therapy, administer first dose on the last day of current antiretrovial therapy or oral lead-in, if used.

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ HIV-1 RNA within the last six months confirming virologic suppression

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____325mg _____500mg _____650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: _____25mg _____50mg
☐ Famotidine: _____20mg _____40mg
☐ Ibuprofen: _____ 200mg _____400mg_____600mg
☐ Ondansetron: _____4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____4mg _____8mg
☐ Diphenhydramine: _____25mg_____50mg
☐ Famotidine: _____20mg_____40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: 100mg
☐ Ondansetron: _____4mg _____8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature *(SIGN BELOW)*

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date