PARAGON HEALTHCARE

CABENUVA INJECTION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

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

OR

☐ Cabotegravir 400mg/rilpivirine 600mg IM every month

Every 2-month adult dosing:

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

OR

☐ Cabotegravir 600mg/rilpivirine 900mg IM every 2 months

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

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

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

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* 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 Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

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: _____

Paragon Healthcare 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.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance