

CABENUVA REFERRAL FORM

PATIENT DEMOGRAPHICS:																			
PATIENT NAME:	PATIENT'S CONTACT #:																		
DATE OF REFERRAL:	ADDRESS:																		
DATE OF BIRTH:	CITY, STATE, ZIP:																		
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:																			
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE MALE																		
WEIGHT: _____ LB or _____ KG	ALLERGIES: NKDA																		
PRIMARY DIAGNOSIS:																			
B20 - Human immunodeficiency virus (HIV) disease Z21 - Asymptomatic human immunodeficiency virus (HIV) infection status Other																			
REQUIRED DOCUMENTATION: Please provide a copy of the following documents.																			
<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back) <input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS <input checked="" type="checkbox"/> 3. MOST RECENT LABS <input checked="" type="checkbox"/> 4. MEDICATION LIST <input checked="" type="checkbox"/> 5. H & P <input checked="" type="checkbox"/> 6. DOCUMENTATION OF ALL FAILED/TRIED THERAPIES																			
<input checked="" type="checkbox"/> Has oral lead-in dosing been initiated? Y N Start Date:																			
PRIMARY MEDICATION ORDER:																			
<p><u>Monthly Dosing:</u> Cabenuva (600 mg Cabotegravir / 900 mg Rilpivirine) IM injection on the last day of current antiretroviral therapy or oral lead-in, followed by Cabenuva (400 mg Cabotegravir / 600 mg Rilpivirine) IM injection every 1 month thereafter.</p> <p><u>Every-2-Month Dosing:</u> Cabenuva (600 mg Cabotegravir / 900 mg Rilpivirine) IM injection on the last day of current antiretroviral therapy or oral lead-in, for 2 consecutive months, and then every 2 months thereafter.</p> <p><i>*Oral lead-in to be prescribed and managed by referring provider</i></p> FIRST DOSE: Y N <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.																			
PRN & PREMEDICATIONS:																			
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">MEDICATIONS</th> <th style="width: 15%;">30 minutes prior to every infusion</th> <th style="width: 35%;">PRN</th> </tr> </thead> <tbody> <tr> <td>Acetaminophen 650 mg PO</td> <td></td> <td>PRN every ____ hour for mild or moderate ifusion reaction.</td> </tr> <tr> <td>Diphenhydramine 25 mg PO</td> <td></td> <td>PRN every ____ hour for mild or moderate infusion reaction.</td> </tr> <tr> <td>Diphenhydramine 25 mg IV</td> <td></td> <td>PRN every ____ hour for mild or moderate infusion reaction.</td> </tr> <tr> <td>Methylprednisolone 125 mg IV</td> <td></td> <td>PRN every ____ hour for mild or moderate infusion reaction.</td> </tr> <tr> <td>Other: _____</td> <td></td> <td>PRN every ____ hour for mild or moderate infusion reaction.</td> </tr> </tbody> </table>	MEDICATIONS	30 minutes prior to every infusion	PRN	Acetaminophen 650 mg PO		PRN every ____ hour for mild or moderate ifusion reaction.	Diphenhydramine 25 mg PO		PRN every ____ hour for mild or moderate infusion reaction.	Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.	Methylprednisolone 125 mg IV		PRN every ____ hour for mild or moderate infusion reaction.	Other: _____		PRN every ____ hour for mild or moderate infusion reaction.
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Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.																	
Methylprednisolone 125 mg IV		PRN every ____ hour for mild or moderate infusion reaction.																	
Other: _____		PRN every ____ hour for mild or moderate infusion reaction.																	
LINE USE/CARE ORDERS:																			
<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE) OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)																			
ADVERSE REACTION & ANAPHYLAXIS ORDERS:																			
<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side) OTHER: (please fax other reaction orders if checking this box)																			
PRESCRIBER INFORMATION: Please check preferred form of communication.																			
PROVIDER NAME:	PHONE:																		
OFFICE CONTACT:	FAX:																		
ADDRESS:	EMAIL:																		
CITY, STATE, ZIP:	NPI:																		
_____ → (GENERIC SUBSTITUTION PERMITTED) PROVIDER SIGNATURE:																			
DATE:																			
_____ → (DISPENSE AS WRITTEN) PROVIDER SIGNATURE:																			
DATE:																			

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.