BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

HIV Drug Treatment Program
CABENUVA® REQUEST FORM

Providence Health Care

When requesting Cabenuva® (cabotegravir and rilpivirine) injections, submit this form with the HIV Treatment prescription request form.
BC-CfE Drug Treatment Program: Fax 604-806-9044. Phone 604-806-8515. www.bccfe.ca

Client and Clinic Information

Client Legal Name (Last, First):	**Date of Birth (DD-MON-YYYY):**	**BC PHN or other billing number:**
Client Address:		**Client Phone:**
Prescriber Name:	**MSC #:**	**CPSID #:**
Prescriber Address:	**Prescriber Phone:**	**Fax:**

☐ Drug delivery site same as prescriber address above. ***OR*** ☐ Other delivery site (specify):

Eligibility Considerations For Cabenuva®

☐ Client stably engaged in care and able to attend in-clinic injection appointments every 4 or 8 weeks.

☐ HIV-1 infection, not subtype A1/A6. [**Subtype**_____ from HIV drug resistance report dated _____]

☐ No evidence or suspected resistance to HIV integrase inhibitors or NNRTIs (with the exception of efavirenz or nevirapine resistance conferred exclusively by a K103 substitution).

☐ BMI < 30 kg/m² (**Caution if BMI ≥ 30**) Height: _____ cm Weight: _____ kg **BMI:** _____ Date: _____

☐ Does not require treatment for Hepatitis B infection. [HBsAg negative Most recent test date: _____]

☐ No contraindications to IM injections (e.g. no anticoagulation therapy, no bleeding disorders, no needle phobia).

☐ If client is of child-bearing potential, confirm not pregnant, or if planning to become pregnant, will not breastfeed while on Cabenuva®. Prescriber to ensure adequate contraception during Cabenuva® therapy.

☐ If Cabenuva® injections are stopped, aware the client should switch to and continue oral ART x 12 months to help prevent development of resistance to integrase inhibitors and non-nucleoside reverse transcriptase inhibitors.

Please provide reason(s) why patient is unable to take preferred oral ART options available in BC (provide supporting documentation):

Confirm Logistical Requirements For Clinic or Delivery Site

☐ has a secure medication fridge that maintains internal temperature 2-8°C.
☐ can support Cabenuva® administration by healthcare provider every 4 or 8 weeks.
☐ has a private area to provide gluteal IM injections.
☐ will arrange medication shipment from St Paul's Hospital Ambulatory Pharmacy at least 2 weeks prior to injections.

Treatment Details

Will the patient receive oral lead-in for cabotegravir + rilpivirine?
☐ **YES, oral lead-in** ☐ **NO**

Pharmacy Use Only (DD-MON-YYYY)

Cabotegravir 30mg, 1 TAB PO daily and Rilpivirine 25mg, 1 TAB PO daily x 30 days.

Start Date

Choose Cabenuva® Injection Regimen Frequency

☐ **Every 4 Week Schedule**

		Injection Date
Injection Loading Dose 1 Give on last day of oral therapy.	*Cabotegravir 600 mg* ***(3mL)*** *+* Rilpivirine 900mg **(3mL)** IM injections.	
First Maintenance Injection Dose Give 28 days after loading dose.	*Cabotegravir 400 mg* ***(2mL)*** *+* Rilpivirine 600mg **(2mL)** IM injections.	

A new prescription is required for subsequent maintenance doses, given every 28 days.

OR

☐ **Every 8 Week Schedule**

		Injection Date
Injection Loading Dose 1 Give on last day of oral therapy.	*Cabotegravir 600 mg* ***(3mL)*** *+* Rilpivirine 900mg **(3mL)** IM injections.	
Injection Loading Dose 2 Give 28 days after loading dose 1.	*Cabotegravir 600 mg* ***(3mL)*** *+* Rilpivirine 900mg **(3mL)** IM injections.	
First Maintenance Injection Dose Give 56 days after loading dose 2.	*Cabotegravir 600 mg* ***(3mL)*** *+* Rilpivirine 900mg **(3mL)** IM injections.	

A new prescription is required for subsequent maintenance doses, given every 56 days.

Prescriber's Signature: **MSC Number:** **Date:**