Prior Authorization Request Form: Cabenuva (cabotegravir and rilpivirine) – CONTINUATION

Date: **Date Form Due Back to Plan:**

Patient Information	
Member Name	
Member ID #	
Member Date of Birth	

Continued Request for Cabenuva will be authorized for a 6-month timeframe: 400 mg/600 mg which is 4ml or 6 units under CPT J3490

Please fill out the information below and return to the Health Plan via Fax: 646-459-7731

If you have any questions, please call the Prior Authorization Department: 866-791-2215 Option 3

Failure to fill this form out and return to the plan by the due date listed above will result in an adverse determination.

Please indicate which dose of Cabenuva you would like to continue for your member: (Continuation requests are approved for 6 months)

________ Cabenuva 400mg/600mg every month

________ Cabenuva 600mg/900mg every other month

Is the member virologically suppressed (HIV-1 RNA less than 50 copies per mL)?	YES NO
Please provide last VL and Date (We expect VL to be tested at least once every 6 months while on Cabenuva)	Last VL :________________ Last VL Date:______________
Is the member currently taking on any of these medications listed? These medications are contraindicated a. Anticonvulsants: Carbamazepine, oxcarbazepine, phenobarbital, phenytoin b. Antimycobacterials: Rifabutin, rifampin, rifapentine c. Glucocorticoid (systemic): Dexamethasone (more than a single-dose treatment) d. Herbal product: St John's wort (Hypericum perforatum) e. Any other antiviral medication for the treatment of HIV-1 and hepatitis.	Yes, the member taking one of the medications, will adjust medication No, the member is currently not on any of the medications
Do you attest that the member has no issues with adherence and is coming in monthly for their injections?	YES NO

Name of Provider:

Signature: Date: