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

Date: **Date form due back to Plan**:

Patient Information	
Member Name	
Member ID #	
Member Date of Birth	

Initial Request for Cabenuva will be authorized for a 6-month timeframe 600mg/900mg which is 6ml or 1 Unit 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 start for your member: (Initial requests are approved for 6 months)

_____ Cabenuva loading dose of 600mg/900mg and then monthly dose of Cabenuva 400mg/600mg thereafter
_____ Cabenuva 600mg/900mg every other month

Does the member have a diagnosis of human Immunodeficiency virus type 1 (HIV-1) infection?	YES ☐	NO ☐
Is the member 18 years of age or older	YES ☐	NO ☐
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 on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine	YES ☐	NO ☐
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	
Did member or will the member receive an oral lead in dose with Vocabria (cabotegravir 30-mg) and Edurant (rilpivirine 25-mg) oral tablets, both taken once daily with a meal, for approximately 1 month (at least 28 days) to assess tolerability? *Please note oral lead in dose is optional*	YES ☐	NO ☐
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: