Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Cabenuva
(cabotegravir/rilprivirine)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * Cigna ID: | * Date of Birth: | |
| Office Fax: | | | * Patient Street Address: | | |
| Office Street Address: | | | City: | State: | Zip: |
| City: | State: | Zip: | Patient Phone: | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication Requested:**
☐ Cabenuva 400 mg/2 mL-600 mg/2 mL suspension
☐ Cabenuva 600 mg/3 mL-900 mg/3 mL suspension
☐ Other (please specify):

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

**Facility and/or doctor dispensing and administering medication:**
Facility Name: State: Tax ID#:
Address (City, State and Zip Code):

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Cabenuva, please choose new start of therapy.
☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a documented clinically beneficial response to treatment with this drug? ☐ Yes ☐ No

**What is your patient's diagnosis?**
☐ Human Immunodeficiency Virus (HIV) type-1
☐ Pre-exposure Prophylaxis (PrEP)
☐ other (please specify):

**Clinical Information**

Does/Did the patient have a HIV-1 RNA less than 50 copies/ml (viral suppression) at BOTH 12 months AND 6 months prior to start of therapy? ☐ Yes ☐ No

Has the patient completed (or will the patient complete) and tolerated 1 month of Vocabria plus Edurant therapy? ☐ Yes ☐ No

(if yes) Prior to initiating Vocabria, was the patient treated with a stable regimen (4 months or longer) of antiretrovirals for HIV-1? ☐ Yes ☐ No

Does the patient have difficulty maintaining compliance with a daily antiretroviral regimen for HIV-1? ☐ Yes ☐ No

(if no) Does the patient have severe gastrointestinal issues that may limit absorption or tolerance of oral medications? ☐ Yes ☐ No

Was this medication prescribed by, or in consultation with, a physician who specializes in the treatment of HIV infection? ☐ Yes ☐ No

Will the patient use other antiretrovirals for HIV concurrently with Cabenuva?

☐ The patient is NOT taking any other antiretroviral(s) for HIV at this time, nor will they in the future. The requested drug is the only antiretroviral the patient is/will be using.
☐ The patient is currently on another antiretroviral for HIV, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another antiretroviral for HIV, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another antiretroviral for HIV.
☐ other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another antiretroviral to treat your patient's diagnosis. _____

**Additional pertinent information** *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

**Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.**

*Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.*

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