PRIOR AUTHORIZATION REQUEST: Cabenuva (cabotegravir and rilpivirine)

Please fax form and required documents to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Address:

PRESCRIBER INFORMATION	
Name/Title:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

MEDICATION REQUEST			
Medication	*Treatment Type*	*Dose*	*Frequency*
CABENUVA Monthly Injection Dosing Schedule	Initiation Injections	600 mg / 900 mg	Once
	Continuation Injections	400 mg / 600 mg	Monthly after initiation injections
CABENUVA Every-2-Month Injection Dosing Schedule	Initiation and Continuation Injections	600 mg / 900 mg	Monthly for two consecutive months, then every two months onward

Is this for initial or renewal treatment?	□ Initial	□ Renewal
Has Vocabria (cabotegravir) and Edurant (rilpivirine) been prescribed to be taken in combination as optional oral lead-in treatment and/or as bridging treatment if indicated?	□ Yes	□ No
Will the provider listed above be ordering and administering this medication? If no, specify provider.	□ Yes	□ No:_____
How will this medication be billed?	□ Pharmacy benefit	□ Medical benefit
Where will the patient be administered this medication?		

CLINICAL CRITERIA			
****Please provide labs/documentation required for verification of questions****			
Labs Required:		□ History of VL ≤50 copies/mL for ≥6 months □ ALL ARV sensitivity/resistance tests	
Baseline Labs (MOST RECENT ≤3 mo.)	**Viral Load**	_____ copies/mL	___/___/_____
	CD4 T-Cell Count	_____ cells/µL	___/___/_____

Prior Treatment History	
Has patient been on a stable ARV regimen with no history of treatment failure for ≥6 months?	□ Yes □ No
Does patient have any known or suspected resistance to either cabotegravir or rilpivirine?	□ Yes □ No
Please provide complete list of medication history and/or failed regimens attached	

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ASSESSMENT OF PATIENT ADHERENCE & EDUCATION READINESS

Prior to starting treatment with the requested medications, healthcare professionals should carefully select patients who agree to the required monthly or every-2-month injection dosing schedule and counsel patients about the importance of adherence to scheduled dosing visits to help maintain viral suppression and reduce the risk of viral rebound and potential development of resistance with missed doses.

If a patient misses a scheduled injection, daily oral bridging therapy is warranted and may replace up to two consecutive monthly injections. If monthly injections are missed and oral therapy has not been taken in the interim, patients will need to be clinically reassessed to determine if resumption of injection dosing remains appropriate.

Adherence

□ Patient demonstrates readiness, willingness, and ability to adhere to the regimen

□ Patient understands the consecutive dosing schedule of both the oral treatment with Vocabria (cabotegravir) and Edurant (rilpivirine) as well as the **Cabenuva** injections, including the importance of adherence to scheduled dosing visits

□ Please describe the patient's adherence to current regimen over past 6-12 months:

_____

Education Readiness

□ Patient understands importance of adherence

□ Patient understands not to engage in risky and unhealthy behaviors

ADDITIONAL PATIENT NEEDS

AMIDA CARE RESOURCES ARE AVAILABLE TO SUPPORT MEMBER ADHERENCE AND LIFESTYLE MODIFICATION

Please check below to request any additional type of support or services for the member:

□ Treatment Adherence Program

□ Other additional support needed for member by Amida Care for the following type of support/education:

_____

Please call 646-757-7979, M-F, 9:00AM – 6:00PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.

_____ ____/____/_____

Prescriber or Authorized Signature Date