Government of District of Columbia Department of Health Care Finance

CABOTEGRAVIR/RILPIVIRINE (Cabenuva™)

Prior Authorization Request

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

PATIENT'S DATE OF BIRTH / /

PATIENT'S FULL NAME

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER: – –

PRESCRIBER FAX NUMBER: – –

PRESCRIBER SPECIALTY:

PRESCRIBER NPI #: –

PHARMACY INFORMATION

PHARMACY NAME

PHARMACY PHONE NUMBER: – –

PHARMACY FAX NUMBER: – –

PHARMACY NPI #:

Summary of FDA Approved Prescribing Information

CABOTEGRAVIR/RILPIVIRINE (Cabenuva™) is an injectable drug indicated as a complete regimen for the treatment of HIV-1 infection in adults and adolescents > 12 years old, and weight > 35kg, to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Please refer to FDA approved product information for prescribing details and approved indications.

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

1. **Is the patent 12 years of age or older and weighs at least 35kg?** ☐ Yes ☐ No
2. **Does the patient have a diagnosis of human immunodeficiency virus type 1 (HIV-1)?** ☐ Yes ☐ No
3. **Patient is virologically suppressed with HIV-RNA < 50 copies/mL and is on a stable antiretroviral regimen?** ☐ Yes ☐ No

   If yes, please provide drug regimen_____
4. **Does patient have history of treatment failure, hypersensitivity reactions or known/ suspected resistance to cabotegravir or rilpivirine?** ☐ Yes ☐ No
5. **Is the patient on any one of the following medications: carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifabutin, rifampin, rifapentine, St. John's Wort, systemic glucocorticoid (dexamethasone for more than a single dose)** ☐ Yes ☐ No
6. **The patient has been counseled about the importance of adherence to scheduled dosing visits and has agreed to contact the prescriber if he/she misses a scheduled injection visit to coordinate a fully suppressive oral treatment for a duration of up to 2 months** ☐ Yes ☐ No

Note: Cabenuva™ is a long-acting HIV treatment medication given IM bilaterally in the gluteus. It must be keep refrigerated until just before administration. Pharmacy must be enrolled in DC Medicaid Mental Health Specialty Network and will deliver the medication to the clinic or physician office where the administration will take place.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

