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**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 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):

**Where will this drug be administered?**
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".
☐ new start (Patient is not receiving the requested medication yet) ☐ Continuation of therapy.

**What is the indication or diagnosis?**

☐ Human immunodeficiency virus (HIV)-1, treatment
☐ Human immunodeficiency virus (HIV)-2, treatment
☐ All other indications or diagnoses

**Clinical Information**

Is the requested medication being prescribed for pre-exposure prophylaxis (PrEP) of human immunodeficiency virus (HIV)-1 Infection? ☐ Yes ☐ No

Is the requested medication being co-administered with antiretrovirals for human immunodeficiency virus (HIV) treatment? ☐ Yes ☐ No

Is documentation being provided showing that the patient has HIV-1 RNA less than 50 copies/mL (viral suppression)? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is the patient currently receiving Cabenuva? ☐ Yes ☐ No

Does the patient weigh greater than or equal to 35 kg? ☐ Yes ☐ No

Is documentation being provided showing that prior to initiating Cabenuva or 1 month lead-in with Vocabria, the patient was treated with a stable regimen (greater than or equal to 3 months) of antiretrovirals for HIV-1? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a physician who specializes in the treatment of human immunodeficiency virus (HIV) infection? ☐ Yes ☐ No

**Additional pertinent information**

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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