Antivirals: HIV –Cabotegravir/rilpivirine (Cabenuva)

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720.
You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   - If yes, does the member have consistent monthly medication use within the last 6 months? ☐ Yes ☐ No

2. What is patient's diagnosis?
   ☐ HIV-1
   ☐ Other. Specify:

3. Is the patient ART-experienced? ☐ Yes ☐ No
   - If yes, Has the patient had virologic suppression for at least 6 months (HIV-1 RNA < 50 copies/mL)?
     ☐ Yes ☐ No

4. Does the patient have a history of any of the following (check all that apply):
   ☐ A history of treatment failure to cabotegravir or rilpivirine
   ☐ Resistance to cabotegravir or rilpivirine
   ☐ None of the above

5. Does patient have documentation of any of the following (check all that apply)?
   ☐ Neurodiversity or a behavioral health condition which impairs the patient's ability to manage multiple or daily medications
   ☐ Severe substance use disorder
   ☐ Diagnosed swallowing disorder
   ☐ Cognitive impairment requiring assistance with activities of daily living
   ☐ None

6. Will Cabenuva be used in combination with other ART medications?
   ☐ Yes. Specify:
   ☐ No

7. Will the patient be using any of the following medications (check all that apply)?
   ☐ Carbamazepine ☐ Dexamethasone (more than single dose treatment)
   ☐ Oxcarbazepine ☐ Phenobarbital ☐ Phenytoin ☐ Rifabutin
   ☐ Rifampin ☐ Rifapentine ☐ St. John's Wort

8. Indicate what date the patient will be initiated on oral cabotegravir and rilpivirine therapy:

CHART NOTES AND LABS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)