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 your patient's diagnosis?

☐ Human Immunodeficiency Virus (HIV) type-1 infection
☐ Human Immunodeficiency Virus (HIV)-2 infection
☐ Pre-exposure Prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV)-1 Infection
☐ other (please specify):

Clinical Information

(if new start) How much does the patient weigh?
☐ 35 kg or more
☐ 34 kg or less
☐ Other/Unknown

(if new start) Prior to initiating Cabenuva or 1 month lead-in with Vocabria (cabotegravir tablets), was the patient treated with a stable regimen (greater than or equal to 3 months) of antiretrovirals for HIV-1? ☐ Yes ☐ No

(if new start) Does the patient have a HIV-1 RNA less than 50 copies/ml (viral suppression)? ☐ Yes ☐ No

(if new start) Did/Does the patient have difficulty maintaining compliance with a daily antiretroviral regimen for HIV-1? ☐ Yes ☐ No

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

(if new start) Is 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 the rationale for concurrent use.

(if continuation of therapy) Does the patient have a HIV-1 RNA less than 50 copies/ml (viral suppression)? ☐ Yes ☐ No

(if no) Please provide support for continued use.

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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