

AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Cabenuva™ (cabotegravir/rilpivirine) LAP (J0741) (Medical)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limit: 1 kit containing two (2) single dose vials per 28 days

- Cabotegravir 400 mg and rilpivirine 600 mg per 2 mL per vial (4 mL)
- Cabotegravir 600 mg and rilpivirine 900 mg per 3 mL per vial (6 mL)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

(Continued on next page)

- Member is 12 years of age or older
- Member must have a confirmed diagnosis of human immunodeficiency virus type -1 (HIV-1)
- Medication is being prescribed by, or in consultation with, an infectious disease specialist or specialist in HIV treatment
- Member has been stabilized **AND** virologically suppressed on current treatment for at least 3 months, defined as HIV RNA copies <50 copies/mL (**must submit chart notes/progress notes displaying regimen from the past 3 months and laboratory documentation of measured level of RNA copies from the past 30 days**)
- Member has **NOT** experienced any treatment failure and not suspected/known to have resistance to either cabotegravir or rilpivirine

Medication being provided by (check applicable box(es) below):

- Physician's office OR Specialty Pharmacy – Proprium Rx

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****