



**BlueCross
BlueShield**

Federal Employee Program.

**CABENUVA
PRIOR APPROVAL REQUEST**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: **1-877-378-4727**

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	<div style="border: 1px solid black; padding: 2px;"> R </div>			Physician Signature:		
PHYSICIAN COMPLETES						

Cabenuva

(cabotegravir/rilpivirine)

*Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

☐ HIV-1 infection

☐ Other diagnosis (*please specify*): _____

2. **Age 12 to 17:** What is the patient's weight? _____ kg **OR** _____ lbs

3. Will Cabenuva be administered by a healthcare professional? ☐ Yes ☐ No

4. Does the prescriber agree to monitor for hypersensitivity reactions, including Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)? ☐ Yes ☐ No

5. Does the prescriber agree to monitor LFTs for hepatotoxicity? ☐ Yes ☐ No

6. Has the patient been on Cabenuva continuously for the last **6 months, excluding samples**? *Please select answer below:*

☐ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Is the patient virologically suppressed (HIV-1 RNA less than 50 copies per milliliter)? ☐ Yes ☐ No

b. Will Cabenuva replace the current antiretroviral regimen? ☐ Yes ☐ No

c. Does the patient have a known or suspected resistance to either cabotegravir or rilpivirine? ☐ Yes ☐ No

d. Does the patient have a history of treatment failure? ☐ Yes ☐ No

e. Has the prescriber counseled the patient regarding the required injection dosing schedule and the importance of adherence to scheduled dosing visits? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Does the patient's HIV-1 RNA remain at less than 50 copies per milliliter? ☐ Yes ☐ No



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster... easier... better...	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA . Sign up today!
	CVS/caremark 