Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Cabenuva – Medical Necessity Request

*****Complete page 1 for Initial Requests Only*****

General Questions:

□ Is the medication prescribed by or in consultation with a physician who is experienced in the treatment of human immunodeficiency virus (HIV) infection? **Yes or No**

□ Please let us know if the member has any of the following (select all that apply):

- □ Member has difficulty maintaining compliance with a daily antiretroviral regimen for HIV
- □ Member has severe gastrointestinal issues that may limit absorption or tolerance of oral medications
- □ None of the above

Contraindications: Please indicate if the member will be concurrently taking any of the following drugs that are contraindicated (select all that apply):

- □ Anticonvulsants: Carbamazepine, oxcarbazepine, phenobarbital, phenytoin
- □ Antimycobacterials: Rifabutin, rifampin, rifapentine
- □ Glucocorticoid (systemic): Dexamethasone (more than a single-dose treatment)
- □ Herbal product: St John's wort (Hypericum perforatum)
- □ None of the above

Diagnosis information (please indicate the diagnosis and answer the related questions):

1. Is the member currently receiving Cabenuva?
   - □ Yes (please answer questions # 2 and #3)
   - □ No (please answer questions #2 through #6)

2. Does the member have HIV type-1 (HIV-1) infection? **Yes or No**

3. Does the member have HIV-1 RNA < 50 copies/mL (viral suppression)? **Yes or No**

4. Has the member completed, or will complete, and is tolerating or will tolerate approximately 1 month of therapy (lead-in) with Vocabria (cabotegravir tablets) + Edurant (rilpivirine tablets)? **Yes or No**

5. Is the member currently receiving antiretrovirals for the treatment of HIV-1 with a stable regimen? **Yes or No**
   a. How long has the member been stable on the current regimen (please provide dates)? _____

6. Does the member have a documented history of suspected resistance to cabotegravir or rilpivirine? **Yes or No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Cabenuva – Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

General Questions:

□ Is the medication prescribed by or in consultation with a physician who is experienced in the treatment of human immunodeficiency virus HIV infection? **Yes or No**

□ Has the member experienced virologic failure while on Cabenuva, defined as two consecutive plasma HIV-1 RNA levels greater than or equal to 200 copies per mL? **Yes or No**

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**