Cabenuva/Apretude Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 280 Avenida Jesus T. Pinero Ste B Rio , PR 00927 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area)

Scheduled Injection Date: _____

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account and health care. Standard data rates apply. Message frequency varies.

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Cabenuva (cabotegravir/rilpivirine extended-release injectable suspension) or Apretude (cabotegravir extended-release injectable suspension). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ **Date:** _____

Patient Authorization

I hereby authorize CVS Specialty to contact my prescribing provider, on my behalf, to coordinate the delivery, receipt and storage of my Cabenuva or Apretude prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. I understand that my signature below serves as the Patient Ship Authorization, which means the pharmacy will not outreach/contact me and/or my designated contact on this form, prior to shipping medication except in certain circumstances.** I further agree to pay to CVS Specialty any required copayment or coinsurance amount, up to a total amount of $50, without prior outreach to me or my designated contact.

Patient's Authorization: _____ **Date:** _____

***CVS Specialty may contact patient and/or patient's designee in the event the patient's copay/coinsurance responsibility is greater than $50. Enrollment above is not available to Medicare and Medicaid patients because government payors are excluded from this offering. Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.*

2 PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Other: _____

Prescriber's First Name: _____ Prescriber's Last Name: _____ NPI#: _____

State License#: _____ DEA#: _____ Practice/Facility Name: _____

Practice Address (Ship to Address): _____ City: _____

State/ZIP Code: _____ Phone Number: _____ Fax Number: _____

Office Contact Name: _____ Contact's Phone: _____

3 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

Diagnosis (ICD-10)

☐ B20 Human Immunodeficiency Virus (HIV) Disease ☐ Z29.81 - Encounter for HIV pre-exposure prophylaxis

☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ lb ☐ kg Height: _____ ☐ in ☐ cm

Has patient previously been treated for HIV? ☐ Yes ☐ No

If YES, list all previous medications: _____

List concomitant medications (e.g., anticonvulsants (Carbamazepine, Oxcarbazepine, Phenobarbital, Phenytoin), antimycobacteri als (Rifampin, Rifapentine, Rifabutin), dexamethasone, St. John's wort)

_____

_____

_____

Cabenuva/Apretude Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Treatment status: ☐ New to therapy ☐ Continuation of therapy: Date of last treatment _____/_____/_____

5 PRESCRIPTION INFORMATION (to be completed by prescriber only)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Apretude			
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ Loading dose (Month 1 & Month 2): Inject 3 mL into the muscle at month 1 and month 2, then every 2 months thereafter	Quantity: 1 dosing kit Refills: 1
☐ Apretude 600 mg Injection Kit	☐ 600 mg/3mL single-dose vial of cabotegravir	☐ Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
Cabenuva			
☐ Option 1: Every-2-Month Dosing			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Loading dose (Month 1 & Month 2): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle once monthly for 2 months then maintenance dose as directed	Quantity: 1 dosing kit Refills: 1
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Maintenance dose (Month 4+): Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
☐ Option 2: Every-1-Month Dosing			
☐ Cabenuva 600/900 mg Injection Kit	☐ 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	☐ Loading dose: Inject 3 mL of cabotegravir and 3 mL of rilpivirine into the muscle on day 1. Follow with maintenance dose in 1 month	Quantity: 1 dosing kit Refills: None
☐ Cabenuva 400/600 mg Injection Kit	☐ 400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	☐ Maintenance dose: Inject 2 mL of cabotegravir and 2 mL of rilpivirine into the muscle every month	Quantity: 1 dosing kit Refills: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature:_____Date: _____	**Prescriber's Signature:_____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.