

# Cabenuva/Apretude Enrollment Form



Fax Referral To: 1-866-279-1993

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-855-801-8262

## 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.*

#### 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), antimycobacterials (Rifampin, Rifapentine, Rifabutin), dexamethasone, St. John's wort)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Cabenuva/Apretude Enrollment Form

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

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
<b>Apretude</b>			
<input type="checkbox"/> Apretude 600 mg Injection Kit	<input type="checkbox"/> 600 mg/3mL single-dose vial of cabotegravir	<input type="checkbox"/> 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: <u>1</u>
<input type="checkbox"/> Apretude 600 mg Injection Kit	<input type="checkbox"/> 600 mg/3mL single-dose vial of cabotegravir	<input type="checkbox"/> Maintenance dose (Month 4+): Inject 3 mL into the muscle every 2 months	Quantity: 1 dosing kit Refills: _____
<b>Cabenuva</b>			
<input type="checkbox"/> Option 1: Every-2-Month Dosing			
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> 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: <u>1</u>
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> 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: _____
<input type="checkbox"/> Option 2: Every-1-Month Dosing			
<input type="checkbox"/> Cabenuva 600/900 mg Injection Kit	<input type="checkbox"/> 600 mg/3 mL single-dose vial of cabotegravir + 900 mg/3 mL single-dose vial of rilpivirine	<input type="checkbox"/> 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: <u>None</u>
<input type="checkbox"/> Cabenuva 400/600 mg Injection Kit	<input type="checkbox"/> 400 mg/2 mL single-dose vial of cabotegravir + 600 mg/2 mL single-dose vial of rilpivirine	<input type="checkbox"/> 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)

May Substitute/ Product Selection Permitted / Substitution Permissible  <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
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**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.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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